Seleme Chiropractic Wellness Center

4002 University Drive, Fairfax, VA 22030
T: 703-273-0573 | F: 703-273-7056

NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY.

Full Name: _____ **Gender**: ☐M ☐F **Age**:____ **Birth Date**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Social Security#: _____-_____-_____ **E-mail** _____ **Home Phone**: (_____) _____

Marital Status: ☐S ☐M ☐D ☐W **# of Children**:____ **Work Status**: ☐Full time ☐Part-time ☐Retired **Cell**: (_____) _____

Females: Last Menstrual Period: _____ **Pregnant?** ☐Y ☐N **Nursing?** ☐Y ☐N **Fax**: (_____) _____

Employer: _____ **Occupation**: _____ **Work Phone**: (____) _____

Employer Address: _____ **City**: _____ **State**:_____ **Zip**: _____

Name of Spouse, Parent or Guardian: _____ **Age**: _____ **Birth Date**: _____ **SS#:** _____-_____-_____

Spouse's Employer: _____ **Spouse's Occupation**: _____ **Work Phone**: (____) _____

In case of an Emergency Contact: _____ **Relationship**: _____

Home Phone: (____) _____ **Cell Phone**: (____) _____ **Work Phone**: (____) _____

Who may we thank for referring you? _____

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Seleme Chiropractic Wellness Center to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Seleme Chiropractic Wellness Center to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

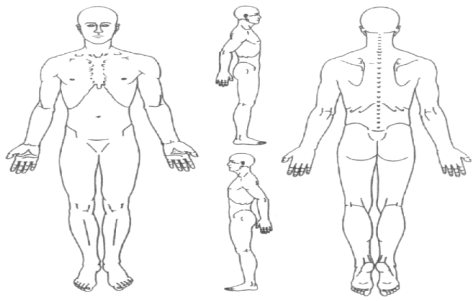
1) _____
2) _____
3) _____
4) _____

TREATMENT: What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.
☐ I am looking to take care of my problem and then go on to "achieve optimal health and wellness."

Please mark on the diagram to the right the following symbols as they relate to the patients' symptoms:

SS = spasms ST = stiffness
DP = dull pain SP = sharp pain
SH = shooting pain TI = tingling
NU = numbness O = Other



COMPLAINT/PROBLEM: In relation to your primary complaint:

When did you first seek treatment for this problem? _____ Has another doctor(s) treated you for this condition: ☐Y ☐N

Whom? ☐MD ☐DO ☐DC ☐DDS ☐Other: _____ Name of primary doctor?_____

Treatment(s) Tried:☐Medication ☐Surgery ☐Lifestyle change ☐ Chiropractic ☐ other_____

Have you had any intolerance or reactions to treatments? ☐Y ☐N Describe: _____

When did the problem start ?: _____ How did it originally occur? _____

Has it become worse recently? ☐Y ☐N ☐Same ☐Better ☐Gradually worse How frequent is the condition? ☐Constant ☐Daily ☐Intermittent

How long does it last? ☐All day ☐Few hours ☐Minutes Is this condition interfering with your? ☐Work ☐ Sleep ☐Daily routine ☐Recreation

Does anything relieve the symptom(s)? ☐Y ☐N ☐ Medication(prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Other: _____

If no, what have you tried? ☐ Medication (prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Surgery

Is there anything that you can do to relieve the symptom? ☐Y ☐N ☐ Medication(prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Other: _____

If no, what have you tried to do that has not helped? ☐ Medication (prescription or OTC) ☐Rest ☐Exercise/Stretch ☐ Surgery ☐Chiropractic

☐Other:_____

How long has it been since you really felt good? ☐Days ☐Weeks ☐Months ☐Years ☐ >10 years

Describe the pain/problem: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Other: _____

What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting ☐Other: _____

What do you believe is cause of the problem?_____

Are there any other conditions or symptoms that may be related to your major symptom? ☐Y ☐N If yes, what? _____

Please check all of the symptoms that apply. (**P**=Past / **C**= Current)

P / C	P / C	P / C	P / C	P / C
☐ ☐ Headache	☐ ☐ High Blood Pressure	☐ ☐ Tingling in Feet	☐ ☐ Facial Pain	☐ ☐ Low Blood Pressure
☐ ☐ Walking Problems	☐ ☐ Eye Pain	☐ ☐ Abdominal Pains	☐ ☐ Sore Muscles	☐ ☐ Blurred Vision
☐ ☐ Nausea/Vomiting	☐ ☐ Weak Muscles	☐ ☐ Dizziness	☐ ☐ Poor Appetite	☐ ☐ Paralysis
☐ ☐ Earache	☐ ☐ Fullness of Bladder	☐ ☐ Shakiness	☐ ☐ Forgetfulness	☐ ☐ Urination Difficulty
☐ ☐ Sweating	☐ ☐ Confusion	☐ ☐ Frequent Urination	☐ ☐ Insomnia	☐ ☐ Sinusitis
☐ ☐ Constipation	☐ ☐ Fainting	☐ ☐ Teeth Grinding	☐ ☐ Hemorrhoids	☐ ☐ Convulsions
☐ ☐ Dry Mouth	☐ ☐ Decreased Sex Drive	☐ ☐ Irritability	☐ ☐ Excessive Thirst	☐ ☐ Menstrual Irregularities
☐ ☐ Impatience	☐ ☐ Unpleasant Taste	☐ ☐ Elbow / Hand Pain	☐ ☐ Fatigue	☐ ☐ Neck Pain
☐ ☐ Tingling in Hands	☐ ☐ Feel Loss of Control	☐ ☐ Sore Throat	☐ ☐ Clammy Hands	☐ ☐ Lump in Throat
☐ ☐ Low Back Pain	☐ ☐ Swallowing Pain	☐ ☐ Hip Pain	☐ ☐ Unsteady Voice	☐ ☐ Knee Pain
☐ ☐ Shoulder Pain	☐ ☐ Poor Circulation	☐ ☐ Persistent Coughing	☐ ☐ Swollen Joints	☐ ☐ Chest Pressure
☐ ☐ Joint Stiffness	☐ ☐ Slow Heart Rate	☐ ☐ Swollen Ankles	☐ ☐ Rapid Heart Rate	☐ ☐ Ankle / Foot Pain
☐ ☐ Other:_____				

Patient's Name: _____Date: _____

ALLERGIES/Sensitivities: Please check and list all allergies.

☐ Food: ☐Dairy ☐Wheat ☐Corn ☐Soy ☐Seafood ☐Gluten ☐Peanuts ☐Fruits ☐Other: _____

☐ Medications: ☐Penicillin ☐Sulfa Drugs ☐Iodine ☐Insulin ☐Antibiotics ☐Other:_____

☐ Seasonal/Other: ☐Pollen ☐Dust ☐Hay ☐Mold ☐Chemical(s) ☐Smoke ☐ Animals ☐Insects ☐Other:_____

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
☐ Antacids		
☐ Antibiotics		
☐ Antidepressants		
☐ Anti-Diabetics		
☐ Anti-Inflammatory		
☐ Blood Pressure Lowering Meds.		
☐ Cholesterol Lowering Meds.		
☐ Hormone Replacements (HRT)		
☐ Oral Contraceptives		
☐ OTC (over the counter) Other		

SCARS / SURGICAL PROCEDURES: Have you had any surgical procedures? ☐YES ☐NO Any Scars? ☐YES ☐NO

SPINE: ☐Cervical ☐Thoracic ☐Lumbar EXTREMITIES: ☐Shoulder/Elbow/Hand/Wrist☐R☐L ☐Hip/Knee/Ankle/Foot ☐R☐L

ABDOMINAL/CHEST: ☐Appendix ☐Colon ☐Gall Bladder ☐Heart ☐Lungs ☐Breast ☐Other:_____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them? _____

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soda / Diet Soda	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type
Exercise	☐	☐	☐	☐	☐Aerobic ☐Weights
	8+ hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs
Sleep	☐	☐	☐	☐	☐
	5+	4	3	2	
Meals / day	☐	☐	☐	☐	
	64+ oz	32-64 oz	16-32 oz	<8 oz	
Water / day	☐	☐	☐	☐	

WORK ACTIVITY: ☐ Heavy Labor ☐ Light Labor ☐ Mostly Sitting ☐ Mostly Standing ☐ Walking / Moving ☐ Driving

FAMILY HISTORY: Identify any conditions that you, or any of your family members have now or have had in the past:
(**F** = Family, **P** = Personal History)

___Alcoholism
___Anemia
___Cancer
___Cold sores
___Deep vein thrombosis
___Detached retina
___Diabetes
___Eczema
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart disease
___HIV / AIDS
___Miscarriage(s)
___Mumps
___Pleurisy
___Pneumonia
___Polio
___Rheumatic fever
___Stroke
___Tumor(s)
___Ulcer(s)
___Other: _____
_____
_____

_____ _____ _____
Patient's Printed Name Patient's Signature Date

Reviewed By: _____ Date: _____