Walsh Family Chiropractic Center | 1139 Professional Drive | Williamsburg, VA 23185| 757.220.4917 | 757.220.5884, fax

Confidential Patient Data

If you need any assistance completing this form, please ask the receptionist.

Legal First Name: _____ Middle Name _____ Last Name: _____

Nickname: _____ Spouse's Name (if applicable) _____

SSN: _____ ❍ Female ❍ Male Date of Birth: ____/____/____ E-Mail Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Preferred method of communication for patient reminders: ❍ Email ❍ Phone ❍Mail ❍Text

Employment Status: ❍ Full-Time ❍ Part-Time ❍ Retired ❍ Un-Employed ❍ Child ❍ Disabled ❍ Homemaker

Occupation Type: _____ Employer's Name: _____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated

*Race: ❍ American Indian or Alaska Native ❍ Asian ❍ Black or African American ❍White (Caucasian)
❍ Native Hawaiian or Pacific Islander ❍ Other ❍ I Decline to Answer

Preferred Language: _____

*Ethnicity: ❍ Hispanic or Latino ❍ Not Hispanic or Latino ❍ I Decline to Answer

How did you hear about us? ❍ Friend/Family Member – Name: _____ ❍ Yellow Pages ❍ Mail
❍ Clinic/Primary Care Physician – Name: _____ ❍ Other: _____

Primary Care Physician _____ Phone (____) _____

Emergency Contact: _____ Relationship: _____

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

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Walsh Chiropractic Center, P.C., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Printed Name: _____ Signature: _____ Date: _____

Informed Consent

I hereby request and consent to the performance of a chiropractic evaluation, chiropractic adjustments, and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Walsh and/or anyone working in this clinic authorized by Dr. Walsh.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and cerebrovascular accidents. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Printed Name: _____ Signature: _____ Date: _____

** CMS requires providers to report both race and ethnicity.*

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Financial Policy

Patient First Name: _____ **Last Name:** _____ **SSN** _____

Person Responsible for Bill

❍ self *(if "self," you do not have to complete the remainder of the information in this shaded box)*

❍ another individual

_____ Date of Birth: ____/____/____
Last Name First Name Middle Name

Mailing Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: _____ Home Phone: (____)_____ SSN _____

Is this person a patient here? _____ Employed By: _____ Work Phone: (____)_____

Business Mailing Address: _____ City: _____ State: _____ Zip _____

Payment for Services will be made primarily by:

❍ Cash ❍ Check ❍ Credit Card ❍ Health Insurance ❍ Automobile Insurance ❍ Worker's Compensation

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. You will have 30 days upon receipt of a Statement of Account to pay in full without penalty. After 30 days you will begin to accrue interest at 14.4% APR.
3. After 90 days, delinquent accounts will be forwarded to a collection agency. At this time all costs associated with collections will become the patient's responsibility. In addition, if you, the patient, choose to acquire an attorney, you, the patient, will be responsible for all attorney fees.
4. A $10.00 processing fee will be charged for all returned checks.
5. This office may make payment plans/arrangements on an individual basis. Any such plan or arrangement will be discussed after your report of findings.
    a. If you enter into a payment agreement and discontinue care before the plan is completed, you will only be responsible for those services that have been provided to date. If the remaining balance is greater than that amount paid to date (due to the nature of the payment plan) the remaining account balance will be due. Should there be a credit, the credit will be refunded to you. If insurance is involved, refunds will be made after all insurance claims have been settled.
6. If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.

It is understood this is a highly specialized, unique and effective method of care. Knowing that 70% of the doctor's knowledge, expertise, time and technical equipment will be utilized in the first three weeks of patient's care; 20% in the second phase, and 10% in the final phase of care.

I have read and understand the Financial Policy.

_____ _____
Patient's Signature Date

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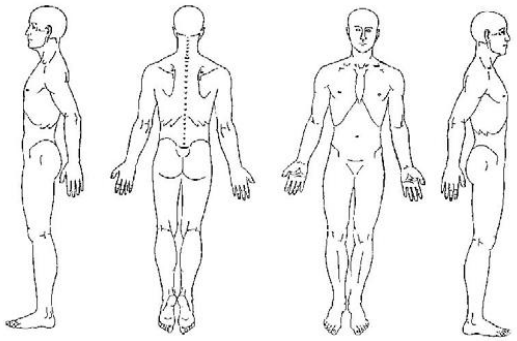
Current Health History

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness Visit

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

Are these complaints a result from a Work Injury, Auto Accident, or Other Accident? ❑No ❑Yes
If yes, explain. _____
Have you experienced these complaints before? ❑No ❑Yes
Has your condition? __ Improved __Worsened __Stayed the same since it began
Have you seen any other doctor(s) for your present complaints(s)?
❑No ❑Yes If yes, who? _____
When? _____
Did you receive MRIs, x-rays, or diagnostic testing? ❑No ❑Yes
What form of treatment did you receive? _____
_____
Are you currently taking any medications for your complaints?
❑No ❑Yes If yes, what?_____



Left Back Front Right

1) Area of Complaint		List Primary Complaint – One Complaint Per Page
When did it begin?		
How did it begin?		
Complaint Rating		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Complaint Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Other:
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Stretching ☐ Bending ☐ Reaching ☐ Twisting / turning ☐ Pushing / pulling ☐ Lifting ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Sneezing ☐ Coughing ☐ Other:
What makes it worse?		☐ General Movements ☐ Bending ☐ Reaching ☐ Twisting / turning ☐ Pushing / pulling ☐ Lifting ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Sneezing ☐ Coughing ☐ Other:
Does the complaint radiate to any other locations?	**Upper Body**	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot
At its worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright Light Sensitivity ☐ Loss of balance ☐ Numbness ☐ Tingling ☐ Tightness ☐ Stiffness
Other Comments or Remarks		

_____ _____
Patient's Signature **Date**

Current Health History, continued

2) Area of Complaint		List Secondary Complaint – One Complaint Per Page
When did it begin?		
How did it begin?		
Complaint Rating		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Excruciating)
Frequency		☐ Infrequent < 25% ☐ Occasional 25% to 50% ☐ Frequent 50% to 75% ☐ Constant > 75%
Complaint Type		☐ No Pain ☐ Pain ☐ Numbness ☐ Tingling ☐ Muscle Spasms ☐ Burning ☐ Aching ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Other:
Severity		☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe
What makes it better?		☐ Medication ☐ Stretching ☐ Bending ☐ Reaching ☐ Twisting / turning ☐ Pushing / pulling ☐ Lifting ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Sneezing ☐ Coughing ☐ Other:
What makes it worse?		☐ General Movements ☐ Bending ☐ Reaching ☐ Twisting / turning ☐ Pushing / pulling ☐ Lifting ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Sneezing ☐ Coughing ☐ Other:
Does the complaint radiate to any other locations?	**Upper Body**	☐ Head ☐ Forehead ☐ Back of head ☐ Right side of head ☐ Left side of head ☐ Neck ☐ Right Ear ☐ Left Ear ☐ Right Eye ☐ Left Eye ☐ Face ☐ Right Jaw ☐ Left Jaw ☐ Right Upper back ☐ Left Upper back ☐ Right Shoulder ☐ Left Shoulder ☐ Right Chest ☐ Left Chest ☐ Right Ribs ☐ Left Ribs
	Mid Body	☐ Right Mid back ☐ Left Mid back ☐ Right Lower back ☐ Left Lower back ☐ Right Hip ☐ Left Hip ☐ Right Buttock ☐ Left Buttock ☐ Groin ☐ Right Arm ☐ Left Arm ☐ Right forearm ☐ Left forearm ☐ Right hand ☐ Left hand ☐ Right fingers ☐ Left fingers
	Lower Body	☐ Right Thigh ☐ Left Thigh ☐ Right Knee ☐ Left Knee ☐ Right Calf ☐ Left Calf ☐ Right Toes ☐ Left Toes ☐ Right Foot ☐ Left Foot
At its worst		☐ Morning ☐ Afternoon ☐ Evening ☐ Night After Activities: ☐ Light ☐ Moderate
Associated with		☐ Dizziness ☐ Nausea ☐ Visual Problems ☐ Ringing/Buzzing ears ☐ Bright Light Sensitivity ☐ Loss of balance ☐ Numbness ☐ Tingling ☐ Tightness ☐ Stiffness
Other Comments or Remarks		

Patient's Initials _____

Date _____

For Additional Complaints, Please Ask Receptionist for Additional Pages

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Current Health History, continued

Date of Last:	< 6 months	6-12 months	>12 months	Never
Spinal examination	❑	❑	❑	❑
Physical examination	❑	❑	❑	❑
Blood test	❑	❑	❑	❑
Chest x-ray	❑	❑	❑	❑
Spinal x-ray	❑	❑	❑	❑
Dental x-ray	❑	❑	❑	❑
Urine test	❑	❑	❑	❑
Habits:	Heavy	Moderate	Light	None
Alcoholic beverages	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑
Recreational drugs	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Appetite	❑	❑	❑	❑

	Current Every Day	Current Some Day	Former	Never
Smoking Habit:	❑	❑	❑	❑

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____

ACCIDENT HISTORY:

1._____ Date:_____ ❑Job ❑Auto ❑Other: _____
2._____ Date:_____ ❑Job ❑Auto ❑Other: _____
3._____ Date:_____ ❑Job ❑Auto ❑Other : _____

OCCUPATION:

Job Title: _____ Years in Job: _____
My typical work day would be described as follows: _____
_____
_____
_____

FAMILY MEDICAL HISTORY M = Mother F = Father S = Sibling C=Children

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

M F S C		M F S C		M F S C	
❑ ❑ ❑ ❑	AIDS/HIV/ARC	❑ ❑ ❑ ❑	Chronic low back pain	❑ ❑ ❑ ❑	Multiple sclerosis
❑ ❑ ❑ ❑	Anemia	❑ ❑ ❑ ❑	Chronic ear infections	❑ ❑ ❑ ❑	Muscular dystrophy
❑ ❑ ❑ ❑	Arthritic disorders	❑ ❑ ❑ ❑	Diabetes	❑ ❑ ❑ ❑	Neuralgia
❑ ❑ ❑ ❑	Asthma	❑ ❑ ❑ ❑	Epilepsy	❑ ❑ ❑ ❑	Polio
❑ ❑ ❑ ❑	Bladder troubles	❑ ❑ ❑ ❑	Heart disease	❑ ❑ ❑ ❑	Reflux
❑ ❑ ❑ ❑	Bowel problems	❑ ❑ ❑ ❑	Hepatitis	❑ ❑ ❑ ❑	Reproductive disease
❑ ❑ ❑ ❑	Cancer	❑ ❑ ❑ ❑	High blood pressure	❑ ❑ ❑ ❑	Sinusitis
❑ ❑ ❑ ❑	Chronic headaches	❑ ❑ ❑ ❑	Kidney disorder	❑ ❑ ❑ ❑	Scoliosis
❑ ❑ ❑ ❑	Chronic neck pain	❑ ❑ ❑ ❑	Migraine headache	❑ ❑ ❑ ❑	Tuberculosis

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Confidential Health Report

This form is for IN-HOUSE USE ONLY. Please check the appropriate box for any of the following symptoms which you now have or have had within the last 6 months. If you are currently taking medication for the symptom, please check the box marked with the letter 'M". We want all the facts about your health before we accept your case.

M – MEDICATION
L6 – LAST 6 MONTHS
C – CURRENTLY

M	L6	C	GENERAL
❑	❑	❑	Allergy
❑	❑	❑	Chills
❑	❑	❑	Convulsions
❑	❑	❑	Dizziness
❑	❑	❑	Fainting
❑	❑	❑	Fatigue
❑	❑	❑	Fever
❑	❑	❑	Headache
❑	❑	❑	Loss of sleep or Apnea
❑	❑	❑	Loss of weight
❑	❑	❑	Nervousness/depression
❑	❑	❑	Neuralgia
❑	❑	❑	Numbness
❑	❑	❑	Sweats
❑	❑	❑	Tremors
			MUSCLE & JOINT
❑	❑	❑	Arthritis
❑	❑	❑	Bursitis
❑	❑	❑	Foot trouble
❑	❑	❑	Hernia
❑	❑	❑	Low back pain
❑	❑	❑	Lumbago
❑	❑	❑	Neck pain or stiffness
❑	❑	❑	Pain between shoulders
			Pain or numbness in:
❑	❑	❑	Shoulders
❑	❑	❑	Arms
❑	❑	❑	Elbows
❑	❑	❑	Hands
❑	❑	❑	Hips
❑	❑	❑	Legs
❑	❑	❑	Knees
❑	❑	❑	Feet
❑	❑	❑	Painful tail bone
❑	❑	❑	Poor posture
❑	❑	❑	Sciatica
❑	❑	❑	Spinal Curvature
❑	❑	❑	Swollen joints
❑	❑	❑	Other: _____

M	L6	C	GASTRO-INTESTINAL
❑	❑	❑	Belching or gas
❑	❑	❑	Colitis
❑	❑	❑	Colon trouble
❑	❑	❑	Constipation
❑	❑	❑	Diarrhea
❑	❑	❑	Difficult digestion
❑	❑	❑	Distension of abdomen
❑	❑	❑	Excessive hunger
❑	❑	❑	Gall bladder trouble
❑	❑	❑	Hemorrhoids
❑	❑	❑	Intestinal worms
❑	❑	❑	Jaundice
❑	❑	❑	Liver trouble
❑	❑	❑	Nausea
❑	❑	❑	Pain over stomach
❑	❑	❑	Poor appetite
❑	❑	❑	Vomiting
❑	❑	❑	Vomiting of blood
❑	❑	❑	IBS
			EYES, EARS, NOSE & THROAT
❑	❑	❑	Asthma
❑	❑	❑	Colds
❑	❑	❑	Crossed eyes
❑	❑	❑	Deafness
❑	❑	❑	Dental decay
❑	❑	❑	Earache
❑	❑	❑	Ear discharge
❑	❑	❑	Ear noises
❑	❑	❑	Enlarged glands
❑	❑	❑	Enlarged thyroid
❑	❑	❑	Eye pain
❑	❑	❑	Failing vision
❑	❑	❑	Far sightedness
❑	❑	❑	Gum trouble
❑	❑	❑	Hay fever
❑	❑	❑	Hoarseness
❑	❑	❑	Nasal obstruction
❑	❑	❑	Near sightedness
❑	❑	❑	Nosebleeds
❑	❑	❑	Sinus infection
❑	❑	❑	Sore throat
❑	❑	❑	Tonsillitis

M	L6	C	CARDIO-VASCULAR
❑	❑	❑	Hardening of arteries
❑	❑	❑	High blood pressure
❑	❑	❑	Low blood pressure
❑	❑	❑	Pain over heart
❑	❑	❑	Poor circulation
❑	❑	❑	Rapid heart beat
❑	❑	❑	Slow heart beat
❑	❑	❑	Swelling of ankles
			RESPIRATORY
❑	❑	❑	Chest pain
❑	❑	❑	Chronic cough
❑	❑	❑	Difficult breathing
❑	❑	❑	Spitting up blood
❑	❑	❑	Spitting up phlegm
❑	❑	❑	Wheezing
			SKIN
❑	❑	❑	Boils
❑	❑	❑	Bruise easily
❑	❑	❑	Dryness
❑	❑	❑	Hives or allergy
❑	❑	❑	Itching
❑	❑	❑	Skin eruptions (rash)
❑	❑	❑	Varicose veins
			GENITO-URINARY
❑	❑	❑	Bed-wetting
❑	❑	❑	Blood in urine
❑	❑	❑	Frequent urination
❑	❑	❑	Inability to control kidneys
❑	❑	❑	Kidney infection or stones
❑	❑	❑	Painful urination
❑	❑	❑	Prostate trouble
❑	❑	❑	Pus in urine
			FOR WOMEN ONLY
❑	❑	❑	Congested breasts
❑	❑	❑	Cramps or backache
❑	❑	❑	Excessive menstrual flow
❑	❑	❑	Hot flashes
❑	❑	❑	Irregular cycle
❑	❑	❑	Menopausal symptoms
❑	❑	❑	Painful menstruation
❑	❑	❑	Vaginal discharge

❑ Yes ❑ No Are you pregnant?

If yes, due date: _____

# of previous pregnancies: _____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

❑	Alcoholism	❑	Cold sores	❑	Goiter	❑	Miscarriage	❑	Scarlet fever
❑	Anemia	❑	Diabetes	❑	Gout	❑	Multiple sclerosis	❑	Stroke
❑	Appendicitis	❑	Diphtheria	❑	Heart disease	❑	Mumps	❑	Tuberculosis
❑	Arteriosclerosis	❑	Eczema	❑	Influenza	❑	Pleurisy	❑	Typhoid fever
❑	Arthritis	❑	Emphysema	❑	Lumbago	❑	Pneumonia	❑	Ulcers
❑	Chorea	❑	Fever blisters	❑	Measles	❑	Rheumatic fever	❑	Whooping cough

Patient's Initials: _____ **Date:** _____

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Medications

Name of Medications (to include prescription drugs & OTC drugs)	Condition	Dosage and Frequency (i.e. 5mg once a day, etc.)

Supplements

Medication Allergies

Medication Name	Reaction	Onset Date	Additional Comments

Patient's Signature **Date**