CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT DATE ____/____/____

PATIENT INFORMATION:

FULL NAME_____ DATE OF BIRTH____/____/____ AGE ____ MALE☐ FEMALE☐

ADDRESS_____ APT#_____ SSN#_____-_____-_____

CITY_____ STATE _____ ZIP CODE_____ HOME PHONE (____)_____

ALTERNATE PHONE (CELL) (____)_____ EMAIL ADDRESS _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

WORK PHONE (____)_____ EXT._____ DATE SYMPTOMS BEGAN ____/____/____

MARITAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT_____ PHONE (____)_____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO: A PERSONAL INJURY ☐ AN AUTO ACCIDENT ☐ A WORK INJURY ☐ OTHER ☐

TYPE OF CLAIM: CASH ☐ PRIVATE HEALTH INS. ☐ AUTOMOBILE ACCIDENT ☐ WORKER'S COMP ☐

I WILL BE PAYING TODAY BY: CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DISCOVER ☐ OTHER ☐

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF ☐ SPOUSE ☐ OTHER ☐ CHILD ☐ SPOUSE:_____

INSURED'S EMPLOYER: SAME AS ABOVE ☐ _____

INSURED'S SSN: SAME AS ABOVE ☐ SSN# _____-_____-_____ INSURED'S DOB: SAME AS ABOVE ☐ ____/____/____

PRIMARY INSURANCE CO._____ ADDRESS_____

CITY _____ STATE_____ ZIP CODE_____ PHONE# (_____)_____

POLICY NUMBER_____ GROUP NUMBER_____

SECONDARY INSURANCE CO._____ ADDRESS_____

CITY _____ STATE_____ ZIP CODE_____ PHONE# (_____)_____

POLICY NUMBER_____ GROUP NUMBER_____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature_____ Date_____

Guardian Signature_____ Date_____

Medical History

Have you been treated for any conditions in the past year? ☐ No ☐ Yes

If yes, please describe

Date of last physical exam

Have you had X-rays taken? ☐ No ☐ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	NO	YES	Briefly Explain
Been hospitalized?	☐	☐	
Been diagnosed with any condition?	☐	☐	
Had surgery?	☐	☐	
Broken bones?	☐	☐	
Been in an auto accident?	☐	☐	
Been struck unconscious?	☐	☐	
Had sprains/strains?	☐	☐	

Currently having:

Fever ☐ Fatigue ☐ Night Sweats ☐ Weight Loss ☐ Retention/incontinence of bowel or bladder ☐

Family History

Family Members – Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	☐ No ☐ Yes
Do your symptoms interfere with daily life?	☐ No ☐ Yes
Does pain wake you up at night?	☐ No ☐ Yes
Are your symptoms worse during certain times of the day?	☐ No ☐ Yes
Do changes in weather affect your symptoms?	☐ No ☐ Yes
Do you wear orthotics?	☐ No ☐ Yes
Do you take vitamin supplements?	☐ No ☐ Yes

What activities aggravate your symptoms?

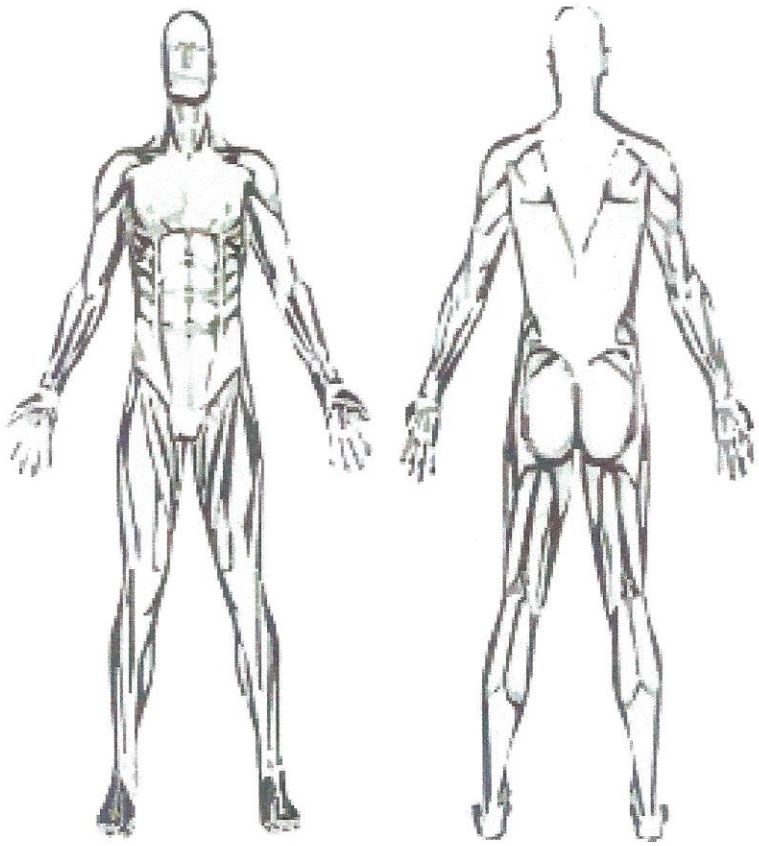
Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

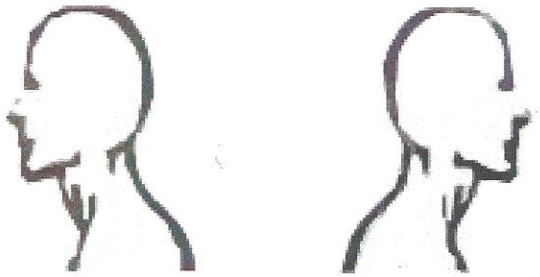
Have you ever suffered from:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Double Vision
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Frequent Urination
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Urinary Tract Infection
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps in Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Night Sweats
- ☐ Nosebleeds
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Sleep Problems or Insomnia
- ☐ Slurred Speech
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vomiting
- ☐ Weight Loss
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache	O=Other
B=Burning	P=Pins & Needles
N=Numbness	S=Stabbing





DR. GREGORY K LEE DC LLC
CHIROPRACTIC PHYSICIAN

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Fairfax, VA 22030
Phone #: 703.373.7113 Fax: 703.373.7595

AUTHORIZATION FOR CHIROPRACTIC TREATMENT

I, the undersigned, a patient in this office, hereby authorize Dr. Gregory K Lee DC LLC to administer such treatment as is necessary, and to perform the following therapy and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of finding during the course of said treatment.

I hereby certify that I have read and fully understand the above Authorization for Chiropractic Treatment, the reason why the above named is considered necessary, the benefits, the risks and the side effects of the treatment and consequences of not having the proposed treatment or possible alternative modes (referrals) of treatment.

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

My doctor responded to all of my requests for information about proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. By signing below, I consent to treatment. I also certify that no guarantee of assurance has been made as to the results they may be obtained.

_____

Name Date

_____

Signature

_____

Parent or Guardian Signature (for minors)