



New Patient Questionnaire

This information is entirely confidential

JOSEPH HENDERSON, DC

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Date: _____

Name: _____ Age: _____ Date of Birth: _____ SSN: _____

Address: _____ City/State: _____ Zip: _____

Phone: Primary: _____ home/work/mobile Secondary: _____ home/work/mobile

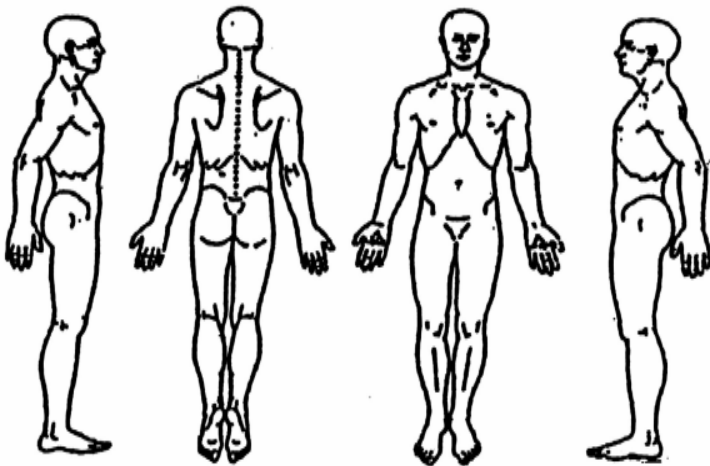
Marital Status: S M DP D W Email address: _____

Who referred you to us? _____ Insurance Company: _____

What is your: Height _____ Weight _____ Occupation _____

What brings you to seek treatment? _____

Please Indicate on the drawings where you have pain/symptoms



Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10

(Please circle)

How long have you had this problem?

How often do you experience your symptoms?

- Constantly Occasionally
 Frequently Intermittently

How would you describe the type of pain?
(select all that apply)

- Sharp Dull Ache Tingly Stiff
 Shooting Burning Stabbing

Other: _____

Are your symptoms Getting Worse Staying the Same Getting Better

Has the problem interfered with your work? social activities? home life?

Who else have you seen for your problem?

- Chiropractor Neurologist Primary Care Physician Orthopedist
 Massage Therapist Physical Therapist No one Other: _____

How do you think your problem began? _____

What aggravates your problem? _____

What relieves your problem? _____

What does it prevent you from doing? _____

How would you rate your overall Health? Excellent Very Good Good Fair Poor

What type of exercise do you do? _____

Any significant medical history with your parents, grandparents, or siblings (i.e., cancer, diabetes, heart disease, etc.):

Have you ever been hospitalized? No Yes if yes, why _____

Have you had significant past trauma? No Yes Explain: _____

Surgical procedures: _____

Current prescription medications: _____



NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE OF THIS NOTICE

March 24, 2008, Revised May 6, 2008

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This notice describes the health information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use health information about you to provide you with health treatment or services. We may disclose health information about you to other personnel (but *only* those personnel) who are involved in taking care of you and your health.

For Payment We may use and disclose health information about you so that the treatment and services you receive at this office may be covered by an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will reimburse you for the service. We may also tell your health plan about a treatment or diagnostic test you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment or test.

For Health Care Operations We may use and disclose your health information to another physician's office to which we refer you.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law, or subpoena.

Research We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the clinic.

Military, Veterans, National Security and Intelligence If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Family and Friends We may disclose health information about you to your family members if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Patient Signature

Date

Patient's Legal Representative
if required (and relationship to patient)

Date