JOSEPH HENDERSON, DC

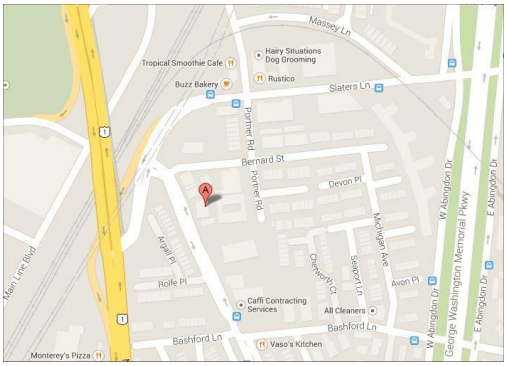
(703) 739-7650 phone
(703) 836-2667 fax
www.chirojoe.com

Please wear loose fitting clothing, as exam and treatment are done in street clothes. Avoid skirts, dresses and snug jeans, though blankets and medical gowns are available if these are unavoidable on the day of your visit.

1423 Powhatan Street, Suite 7
Alexandria, VA 22314

The Alexandria office is located at the Body in Balance Center in the Station Square office complex. Ample street parking is available, either on Powhatan Street or behind the building on Portner Road (sign at the rear entrance reads 1423 Portner). From the front, walk through the iron gate, up the stairs and into the courtyard. Suite 7 is the last door on the left. From the Portner side, go up the stairs into the courtyard and Suite 7 is the first door on the right. Elevator access is available from the rear (Portner) entrance. If the receptionist is not available, just have a seat in the waiting area. Help yourself to water or tea.

Map Link



1712 I (Eye) Street, Suite 1012
Washington, DC 20006

There is no parking other than metered street parking (highly restricted during rush hour). The office is one block from both the Farragut North metro station (Red Line) and the Farragut West metro station (Yellow, Blue, Silver Lines)

A photo ID is required for admittance to the building before proceeding to the elevators

Please refrain from the use perfumes/colognes on the day of your appointment or you will most likely be asked to leave and reschedule. Someone on site is highly allergic.

For Security reasons the door to the suite is locked. Please ring the bell. You may have to wait a moment or two if I am in session with someone. Feel free to ring again if you are wondering if it was heard.

Map Link

Confidential New Patient Questionnaire

Joseph Henderson, DC – www.chirojoe.com – (703) 739-7650

1423 Powhatan St., Suite 7
Alexandria, VA 33314

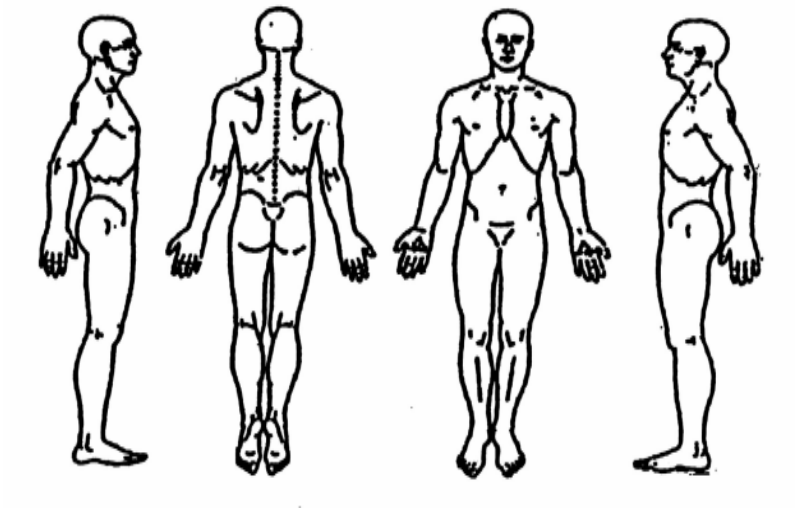
1712 Eye St. NW, Suite 1012
Washington, DC 20006

Name: _____Date: _____ Age:_____ Date of Birth:_____
Address:_____City/State:_____Zip:_____
Phone: Primary:_____home/work/mobile Secondary:_____home/work/mobile
Gender Identity/Expression: *see note_____Email address:_____
Marital Status: __S __M __DP __D __W Who referred you to this office?_____

What is your: Height_____ **Weight** _____ **Occupation** _____

What brings you to seek treatment?_____

Please Indicate on the drawings below 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
□ ER physician □ Orthopedist □ Other:_____
□ Massage Therapist □ Physical Therapist □ No one

How do you think your problem began?_____

What positions or activities aggravate your problem?_____

What positions or activities relieve 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? _____

Is there any significant family medical history (i.e., cancer, diabetes, heart disease, etc.)?

_____

_____

****If Gender identity/expression is different from that on your insurance registration, please advise.**

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Stroke
□	□	Diabetes	□	□	Heart Problems	□	□	Chest Pains
□	□	Neck Pain	□	□	Excessive Thirst	□	□	Abnormal Weight Gain/Loss
□	□	Back Pain	□	□	Frequent Urination	□	□	General Fatigue
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Muscular Incoordination	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Cancer	□	□	Chronic Sinusitis
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	□	□	Drug/Alcohol Dependence
□	□	Joint Pain/Stiffness	□	□	Arthritis	□	□	Ulcer
□	□	Jaw Pain	□	□	Asthma	**Females:**		
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder	□	□	Hormonal Replacement
□	□	Hepatitis	□	□	Smoking/Tobacco Use	□	□	Birth Control Pills
□	□	Dizziness	□	□	Visual Disturbances	□	□	Pregnancy
□	□Other:_____					**Males**		
						□	□	Prostate Cancer/Hypertrophy (circle)

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

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

Current prescription medications:_____

Current Over-the-counter medications/supplements you are currently taking:

_____

Surgical procedures:_____

What activities do you do at work?_____

What activities do you do outside of work?

_____

Anything else pertinent to your visit today?_____

CONSENT TO CARE:

A patient coming to the doctor gives him/her permission and authority to provide care in accordance with appropriate tests, diagnosis, and analysis. The procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the patient's responsibility to disclose all latent medical/pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

_____

Patient's Signature Date

DISCLOSURE OF FEES/PAYMENT POLICY

I understand that I am responsible for payment for services rendered at the time of rendering. I understand that the office will generate a receipt for me to submit to my insurance company for reimbursement if necessary. I understand that if a check is returned for insufficient funds, I will be charged a $25.00 service charge.

I understand that I must cancel an appointment before the close of business on the previous business day or else I will be charged for the visit. I understand that missed appointments will be charged to me.

Signed_____ Date_____

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE OF THIS NOTICE
March 24, 2008, Revised April 29. 2013

JOSEPH HENDERSON, DC
1423 Powhatan St., Suite 7
Alexandria, VA 22314
(703) 739-7650 phone
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This notice describes the health information privacy practices followed by our employees, staff and other clinic personnel.

YOUR HEALTH INFORMATION

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

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 clinic 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) Relationship