CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance card(s). All information you supply is confidential. We comply with all Federal privacy standards. Please print clearly.

Patient Name: _____ **Date:** _____

Dr. Robert W. Breen, D.C.
8565 A Sudley Road
Manassas, VA 20110-3864
Ph: 703 368-4040
400 Holiday Court, Ste 206
Warrenton, VA 20186
Ph: 540 349-7744

What are the top 3 complaints you are being seen for today:

1)	2)	3)

Describe the onset of symptoms and date of onset if known for each condition:

1) Date:	2) Date:	3) Date:

Have you experienced these symptoms before:

1) □ Never □ On and off □ For Years	2) □ Never □ On and off □ For Years	3) □ Never □ On and off □ For Years

How do you feel your symptoms are changing with time:

1) □ Improving □ Worsening □ No change	2) □ Improving □ Worsening □ No change	3) □ Improving □ Worsening □ No change

What are the qualities of these symptoms:

1) □ Achy □Burning □Dull □Sharp □Stiff □Throbbing □Tight □Sore □ Other: _____	2) □ Achy □Burning □Dull □Sharp □Stiff □Throbbing □Tight □Sore □ Other: _____	3) □ Achy □Burning □Dull □Sharp □Stiff □Throbbing □Tight □Sore □ Other: _____

On a scale of 1-10 (0=no pain, 10=most severe pain) how would you rate the intensity of your pain today:

1) 1-10: _____	2) 1-10: _____	3) 1-10: _____

How often do you experience your symptoms:

1) □Occasionally □Intermittent □Frequently □Constant	2) □Occasionally □Intermittent □Frequently □Constant	3) □Occasionally □Intermittent □Frequently □Constant

What time of the day do your symptoms feel better:

1) □AM □Mid-Day □PM □None	2) □AM □Mid-Day □PM □None	3) □AM □Mid-Day □PM □None

What aggravates your symptoms:

1)	2)	3)

What alleviates your symptoms:

1)	2)	3)

Have you seen another provider for this condition (If so please provide their name and when):

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

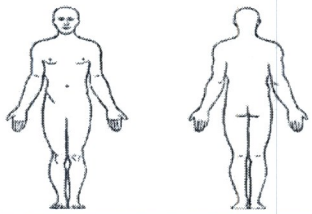
Dr.'s Initials:

Please answer the next 3 sections only if they apply to the condition(s) you are seeking treatment for:

Lower Back Pain

Does the pain radiate into your leg(s)? □Yes □No
If yes, please describe: _____
Does the pain radiate into your abdomen? □Yes □No
Do you have any impairment of the bowel or urinary function? □Yes □No
Do you have numbness or tingling into the leg(s)? □Yes □No
If yes, please describe: _____

Please mark on the bodies where you're having pain/symptoms:



Neck/Upper Back Pain

If you have a neck injury, does it affect: (check all that apply) □Hearing □Vision □Balance □Cause ringing in ears
Do you hear grating sounds? □Yes □No **Do you feel pressure or pain behind your eyes?** □Yes □No
Does the pain radiate into your arm(s) □Yes □No Where: _____
Do you have difficulty turning your head? □Yes □No **If so in which direction?** □Right □Left □Up □Down

Headaches

Do you get headache's? □Yes □No **If yes how often?** _____ per day/week/month
Location of headache's : _____ **Does medication help your headaches:** □Yes □No
Do you experience the following with your headache's: Pain or cracking in the jaw- □Yes □No
Abnormal blood pressure-□Yes □No Nausea, vomiting or visual disturbances-□Yes □No
When was your last eye exam by a doctor? _____ Results of exam: _____

If you are female are you pregnant? □Yes □No □Not sure Date of last menstrual period: _____

Please list current medications/vitamins/supplements and the frequency and dosage if known. □None currently

1)_____ Start Date: _____ Frequency: _____ Dosage: _____
2)_____ Start Date: _____ Frequency: _____ Dosage: _____
3)_____ Start Date: _____ Frequency: _____ Dosage: _____
4)_____ Start Date: _____ Frequency: _____ Dosage: _____
5)_____ Start Date: _____ Frequency: _____ Dosage: _____

List any known allergies you have had to any medications: □No known allergies

Medication: _____ Symptoms Associated: _____
Medication: _____ Symptoms Associated: _____
Medication: _____ Symptoms Associated: _____

Have you ever had any surgeries or hospitalizations? □Yes □No If yes, please list:

Type of surgery/hospitalization:	Date:	Type of surgery/hospitalization:	Date:
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed, had an MRI or CT Scan in the last 12-18 months? □Yes □No When/Where _____

Have you seen a Chiropractor before? □Yes □No Who/When _____

Do you have a primary care physician? □Yes □No Who _____ _____

Have you ever had a □Motor Vehicle Injury □Sports Injury □Work Injury □Slip/Fall Injury If yes please explain:
_____

Patient Name: _____ Doctor's Initials: _____

Has any doctor diagnosed you with Hypertension presently? □**Yes** □**No** If yes, who and when: _____

Has any doctor diagnosed you with Diabetes presently? □**Yes** □**No** If yes, what kind: □**Type 1** □**Type 2**

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c >9.0%? □**Yes** □**No**

Please check all additional complaints you have currently or had in the past:

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
□	□	Osteoporosis	□	□	Arthritis	□	□	Scoliosis	□	□	Neck pain	□	□	Back problems
□	□	Hip disorders	□	□	Knee injuries	□	□	Foot/ankle pain	□	□	Shoulder problems	□	□	Elbow/Wrist pain
□	□	TMJ issues	□	□	Poor posture	□	□	Anxiety	□	□	Depression	□	□	Headaches
□	□	Dizziness	□	□	Pins & Needles	□	□	Numbness	□	□	High Blood Pressure	□	□	Low Blood Pressure
□	□	Angina	□	□	Bruising	□	□	High cholesterol	□	□	Poor circulation	□	□	Asthma
□	□	Apnea	□	□	Emphysema	□	□	Hay fever	□	□	Shortness of breath	□	□	Pneumonia
□	□	Eating disorder	□	□	Ulcer	□	□	Heartburn	□	□	Food sensitivities	□	□	Constipation
□	□	Diarrhea	□	□	Blurred vision	□	□	Ear ringing	□	□	Hearing loss	□	□	Chronic ear infections
□	□	Loss of smell	□	□	Loss of taste	□	□	Skin Cancer	□	□	Psoriasis	□	□	Eczema
□	□	Acne	□	□	Hair loss	□	□	Rash	□	□	Thyroid issues	□	□	Immune disorders
□	□	Hypoglycemia	□	□	Swollen glands	□	□	Low energy	□	□	Frequent infection	□	□	Kidney stones
□	□	Infertility	□	□	Bedwetting	□	□	Prostate issues	□	□	Erectile dysfunction	□	□	PMS symptoms
□	□	Fainting	□	□	Low libido	□	□	Poor appetite	□	□	Fatigue	□	□	Weakness
									□	□	Sudden weight gain	□	□	Sudden weight loss

Do you have any diseases or medical problems not listed? □Yes □No If yes, please list:_____

Family History (Some issues are hereditary, please tell us about the health of your immediate family members):

Relative:	Age(if living):	State of Health:	Illnesses:	Age at death:	Cause of Death:
Mother		□Good □Poor			□Natural □Illness
Father		□Good □Poor			□Natural □Illness
Sister 1		□Good □Poor			□Natural □Illness
Sister 2		□Good □Poor			□Natural □Illness
Brother 1		□Good □Poor			□Natural □Illness
Brother 2		□Good □Poor			□Natural □Illness
Other		□Good □Poor			□Natural □Illness

Social History (Please tell us about your health habits):

Select all of the following that apply to complete this statement:

I Smoke_____ □Never □Current Daily Smoker □Current sometimes Smoker □Former Smoker □Decline to answer

If a current smoker what is your level of interest in quitting smoking? □Not interested □Somewhat interested □Very interested

Alcohol Consumption: □None □Casual Drinker □Moderate Drinker □Heavy Drinker □Decline to answer

Caffeine Consumption: □None □<3 drinks day □3-6 drinks day □>6 drinks day □Decline to answer

Drug Use: □None □Recreational □Addiction □Decline to answer

Exercise: □Never □Daily □Weekly □Decline to answer

Is there any additional information you would like the doctor to know about before beginning care? _____

Clinician ONLY Notes:

HT: _____

WT: _____

BP: _____ P: _____ : □ Follow up recommended with PCP □ No Follow up needed □ Already under PCP care

Patient Name: _____ Doctor's Initials: _____

Personal Information

Today's Date: _____ **Whom may we thank for referring you?** _____

Patient's Name: _____ _____ _____ _____ _____
(First name) (M.I) (Last name) (suffix) (Nickname)

Birth Date: _____ **Age:** _____ **Sex:** □M □F **SS#:** _____

Marital Status: □Single □Married □Divorced □Legally separated □Widowed □Partnered **Spouse Name:** _____

Race: □White □Black □Asian □American Indian □Native Hawaiian/Pacific Island □Other _____

Ethnicity: □ Hispanic or Latin □Not Hispanic or Latin **Multi-Racial:** □Yes □No □Unknown

Preferred Language: □English □Spanish □Other _____

Contact Information

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

Email Addresses: (H): _____ (W): _____

Phone #'s: (H): _____ (C): _____ (W): _____

Preferred method of contact: □ Home Email □Work Email □Home Address □Home Phone □Cell Phone □Work Phone

Emergency Contact: _____ Relationship: _____ P: _____

Occupational Information

Employment Status: □Full-time □Part-time □Student □Homemaker □Unemployed □Retired

Occupation: _____ **Employer:** _____

Job Requirements: □Sit □Stand □Bend □Lift □Carry □Travel □Other: _____

Insurance Information

Is this condition due to an accident? □ Yes □ No Date of Accident: _____ Type: □ Auto □ Work □ Home □ Other

Primary Insurance Company: _____ Policy Holder Name: _____ DOB: _____

Who is financially responsible for this account: □ Self □ Parent □ Other: _____

By signing below I am stating that to the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient or Guardian Signature: _____ Date: _____

Breen Chiropractic Center, P.C.
Robert W. Breen, D.C.

Authorization & Assignment

I authorize **Robert W. Breen, D.C.** to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me. I authorize the direct payment to you of sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services. I understand that whatever amounts you do not collect from insurance proceeds (whether it is all or part of what is due) I personally owe you. Our Notice of Privacy Practices provides detailed information about how we may use and disclose this protected health information & is available by request for review. You have a legal right to review our Notices of Privacy Practices before you sign this consent, and we encourage you to read it in full. I, the undersigned do hereby appoint **Robert W. Breen, D.C.** authority necessary to endorse and cash my checks, drafts or money orders which are payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by this clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charges 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 professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect any monies owed.

Patient or Guardian signature:_____**Date:**_____

Informed Consent

I hereby authorize the physician and staff at the offices of **Dr. Robert W. Breen, D.C.** to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the information provided in this paperwork is correct to the best of my knowledge. I will not hold my doctor or any staff member of the offices of **Dr. Robert W, Breen, D.C.** responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Patient or Guardian signature:_____**Date:**_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

_____
Signature

_____
Date

Total Score _____

Updated Date/Score: _____ / _____
Updated Date/Score: _____ / _____

RELEASE OF MEDICAL INFORMATION

Date: _____

Patient's Name: _____

I hereby authorize you to release any and all medical records/x-ray reports concerning the above mentioned patient to **Breen Chiropractic Clinic, P.C. 8565-A Sudley Road, Manassas, VA 20110. Phone: 703/368-4040, Fax: 703/361-1177.**

Patient's Signature: _____

DOB: _____

SSN: _____