## Rolling Valley Chiropractic Centre Admissions Information: Intake Form

Please Print Clearly

Name:	Social Security # (Patient ID):						
Address:	onservers to b	Home Phone	e:				
Address: State: City: State: Date of Birthday (mm/dd/yyyy):	Zip:	Cell Phone:					
Date of Birthday (mm/dd/yyyy):	Age: _	Sex: M	ofen and over				
E-mail address:	A TIME ISSUED TO BE	BENEFICE TRUET BROKES					
E-mail appointment reminders? Y	N						
Employer Name:	A SHAREST SALES	Phone:	DIBLICATION OF BOARDS				
E-mail address: E-mail appointment reminders? Y Employer Name: Employer Address: Spouse/Guardian:	and production to the second	andronathermens but a trace of the same sale world and below the	s <del>endent to proportion</del>				
Spouse/Guardian:	THE RESERVE THE PROPERTY OF TH	_(N/A) Phone:	caraca time il caraca				
all british of minh and secures INNER and							
Insurance Information:							
Insurance Co. Name:							
Insured's Name:	lns	sured's Date of Birth	1:11				
ID #:	Group #:						
Insurance Co. Name: Insured's Name: ID #: Patient's Relationship to Insured (circle of	one): Self	Spouse Child	Other				
Primary Care Physician:		Phone:					
Primary Care Physician: Emergency Contact Phone:	Relation	nship to Patient:					
Emergency Contact Phone:	ATTENDED FOR THE SAME	A SE A DECE					
Patient Payment: I will be paying today by (circle one): C  Office Policy, Patient Agreem with Rolling Vall	ent, And Re	equest/Consent fo					
I hereby request and consent to trand agree that health and accident in insurance carrier and myself. It is under are rendered. In special instances, RV0 portion of the balance due. However, rendered me are charged directly to me Returned checks and balances older that Accounts that require collection services be made for missed appointment with 24 I certify that all intake information is notify you of any changes in my health st	erstood that perstood that per	licies are an arrar bayment is due at the ept assignment of lerstand and agree am personally respect to addressed a 25% attorned arrect to the best of bove information.	the time that services insurance benefits as that all services are consible for payment. itional collection fees. ey fee. Charges may my knowledge. I will				
Signature:(Parent/Guardian if minor)		Date:					
(Parent/Guardian if minor)		(forgout)	Signature of Claim and C				
Witness (office personnel only):			Office Parsonnal Signal				

### Rolling Valley Chiropractic Centre 9279 Old Keene Mill Road, Burke, VA 22015

# Office Policy: Assignment of Insurance Benefits

We offer the option of insurance assignment, on a select basis, strictly as a courtesy to our patients. As such, our patients must understand that out relationship is with you and not the insurance carrier. You must supply RVCC with all appropriate insurance information to process claims. Regardless of insurance status, you are responsible for full payment for any and all services rendered to you; any un-met deductibles or fees not paid by your carrier; and for your co-pay (the part of the bill not paid by the insurance carrier). Your co-pay must be paid at the time of service. If your carrier had not paid a claim within 60 days of submission you are responsible to take an active part in the recovery of that claim. After 90 days, RVCC reserves the right to rescind its assignment. At that time, you will be asked to pay the balance of your bill in full.

#### PATIENT'S ASSIGNMENT OF INSURANCE PAYMENT BENEFITS

For the treatment provided to me, I hereby authorize the obligated insurance company to pay by check, made-out and mailed directly to:

> Rolling Valley Chiropractic Centre 9279 Old Keene Mill Road Burke, VA 22105 Tax I.D. # 54-1306944

for the benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the charges for professional services rendered. (If my current policy prohibits direct payment to the doctor, then I hereby authorize you to make the check to me and mail it directly to the Rolling Valley Chiropractic Centre address listed above).

I agree to pay, in a currently and timely manner, any balance of charges over and above this insurance payment.

This is a direct assignment of my rights and benefits under this policy and includes all rights to collect payment directly from my insurance company. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

ı	have read,	understood	and agi	ee to	the above	condition	of as	ssignment	of benefits.
---	------------	------------	---------	-------	-----------	-----------	-------	-----------	--------------

Datenollsmuchil avods online	
Signature of Policy Holder	Signature -
Signature of Claimant (Patient)	(Parent/Guardian if minor)
Office Personnel Signature	Witness (office personnel only)

# Patient Health Questionnaire - PHQ ACN Group, Inc. Form PHQ-202

Patient Name		Date		
1. Describe your symptoms	9784			onin'i in
d Moderale S Strentique	18000	onal/ 0 ten	receive on you perfor	ta viluges to east.
and In I saniny		Anthrea model	Cadananak	and desired necessarial
a. When did your symptoms start?		The space of the space		the transfer territ de
b. How did your symptoms begin?				27.5
<ul> <li>2. How often do you experience your</li> <li>① Constantly (76-100% of the day)</li> <li>② Frequently (51-75% of the day)</li> </ul>	symptoms?	Indicate where you have p	ain or other symptoms	
<ul><li>Occasionally (26-50% of the day)</li><li>Intermittently (0-25% of the day)</li></ul>		APE	1 /F. X	
<ul> <li>3. What describes the nature of your</li> <li>① Sharp</li> <li>② Dull ache</li> <li>③ Numb</li> <li>⑥ Tingling</li> </ul>	symptoms?			The last
<ul> <li>4. How are your symptoms changing</li> <li>① Getting Better</li> <li>② Not Changing</li> <li>③ Getting Worse</li> </ul>	?			
5. During the past 4 weeks:  a. Indicate the average intensity of y	your symptoms	None	(a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	Unbearable
b. How much has pain interfered with	th your normal  ② A little bit	work (including both work outsi Moderately	de the home, and housewo	(S) Extremely
6. During the past 4 weeks how much (like visiting with friends, relatives, etc.)	of the time h	as your condition interfere	d with your social activ	vities?
① All of the time	2 Most of the	time 3 Some of the time	A little of the time	None of the time
. In general would you say your over	all health righ	t now is		one selections of the control of the
① Excellent	2 Very Good	3 Good	Fair	⑤ Poor
3. Who have you seen for your sympt	foms?	No One     Other Chiropractor	Medical Doctor     Physical Therapist	⑤ Other
a. What treatment did you receive a	and when?	O Discostos O as	reldor <sup>©</sup> heart Droblem	distriba biofemeers
b. What tests have you had for your	symptoms	① Xrays date:	③ CT Scan date:	The same that
and when were they performed?	② MRI date:	Other date:	is a management of the	
). Have you had similar symptoms in	the past?	① Yes	② No	
a. If you have received treatment in the same or similar symptoms, who		1 This Office 2 Other Chiropractor	<ul><li>Medical Doctor</li><li>Physical Therapist</li></ul>	⑤ Other
10. What is your occupation?		<ul><li>① Professional/Executive</li><li>② White Collar/Secretarial</li><li>③ Tradesperson</li></ul>	<ul><li> Laborer</li><li> Homemaker</li><li> FT Student</li></ul>	© Retired  ® Other
a. If you are not retired, a homemal student, what is your current work s		① Full-time ② Part-time	<ul><li>3 Self-employed</li><li>4 Unemployed</li></ul>	⑤ Off work ⑥ Other
Patient Signature			Date	

## Patient Health Questionnaire - page 2 American Chiropractic Network

ype of regular exercise do you possible son son possible son	erform?	• • • • • • • • • • • • • • • • • • •	@ Light		3 Moderate	Strenuou	
s your height and weight?							s
		Height	Til		Weight	lb:	S.
		Feet	Inches				
ch of the conditions listed below	v place	a check in the Past co	lumn if vou	have	had the cond	ition in the n	ast
					transfer wooth		
Present	Past	Present		Past	Present	2) vimermer ?	
O Headaches	0	O High Blood Pressur	е	0	O Diabetes	vilannia anno	
O Neck Pain	0.			0			
O Upper Back Pain	0	O Chest Pains		. 0	O Frequent	Urination	
O Mid Back Pain	0	O Stroke		s they	to exist sets	mat deserbed	
O Low Back Pain	0			0			
O Shavildas Bais	0		12.	0	→ Drug/Alc	ohol Depende	ence
		. H. 그렇게 하는 사람들이 되었다. 하는 사람들은 사람들은 사람들은 사람들은 사람들이 되었다.		0	O Alleraion	dnuVid	
그렇게 살아 있는 아이들이 얼마 아이들이 얼마 나는 그들이 살아 있다면 살아 먹었다.							
							ri de
O Hand Pain					•	Married and a company of the company	
O Hin/I Inner Lea Pain	.0		ntrol				9
	0	O Prostate Problems					ish
	0	O Abnormal Weight G	ain/Loss	0	O HIVIAIDS	3	
Ankierroot Fair		그 전 그 경기 이번 경기에 들어가 되었다면 중에 없는 사람들이 되었다.		For	nales Only		
O Jaw Pain						1-10:11-	
O loint Swalling/Stiffages			MARKET MILLS P	1980	the state of the state of the state of the state of	A STREET, STRE	
- Barting Control (1) : 1 : 1 : 1 : 1 : 1 : 1 : 1 : 1 : 1 :			STATE AS				II
	White his work		licardor		the second of the state of what the	y :	
C Miedinatola Artifitis	O		Jisordei	0	desert the sale		
O General Fatigue		마실 때문에서 발매를 내려가 되었다는 그 생각이 되었다.		Oth	er Health Pro	blems/Issues	;
<ul> <li>Muscular Incoordination</li> </ul>	0	O Tumor		0	0		
O Visual Disturbances	. 0	O Asthma	gir dilinedi.bi	0	0		
O Dizziness	0		cop nov s	0	0		
•				,			
to 16 on immediate femilie month		and more and the falls with a	Same				
[일] 그 아이지 않는데 그래요 하게 되었다. 이 그리고 있는데 그는 그는 그리고 있다.				_	1		
neumatoid Arthritis O Heart Pro	blems	O Diabetes O	Cancer	0	Lupus O_		
The second of th				MISSING T			
prescription and over-the-cour	iter med	lications, and nutritions	al/herbal su	ppler	nents you are	taking:	
Since Sales	16	was a second of the second	·				
			Vison on			a tradet e consideration	
				. ,			
the surgical procedures you ha	ive had	and times you have be	en nospital	ized:	received as each	sent not yet	
Filikares matabas	. 10	TOESCHOOLS - WHILE IS	HUNK BOX 1830	Christ	Carried Mary Strait.	As (10) (22) (20)	
Laborer CD Relifed		ducerdijanovastorA D					
Homerhaket © Other							
Signature		* extendoceable T (S)		Date	)		
r's Additional Comments							
the activities of the control of the							
*	Present Headaches Neck Pain Upper Back Pain Low Back Pain Shoulder Pain Elbow/Upper Arm Pain Wrist Pain Hand Pain Hip/Upper Leg Pain Knee/Lower Leg Pain Ankle/Foot Pain Jaw Pain Joint Swelling/Stiffness Arthritis Rheumatoid Arthritis General Fatigue Muscular Incoordination Visual Disturbances Dizziness  te if an immediate family member seumatoid Arthritis Heart Pro-	Present Pleadaches Neck Pain Upper Back Pain Low Back Pain Shoulder Pain Elbow/Upper Arm Pain Wrist Pain Hand Pain Hip/Upper Leg Pain Knee/Lower Leg Pain Jaw Pain Joint Swelling/Stiffness Arthritis Rheumatoid Arthritis General Fatigue Muscular Incoordination Visual Disturbances Dizziness  Prescription and over-the-counter medicate family member has here and the surgical procedures you have had a signature	Present Past Present Headaches Headaches Neck Pain Heart Attack Upper Back Pain Low Back Pain Shoulder Pain Elbow/Upper Arm Pain Hand Pain Hip/Upper Leg Pain Ankle/Foot Pain Joint Swelling/Stiffness Arthritis Rheumatoid Arthritis Dizziness  Past Present High Blood Pressur Heart Attack Chest Pains Chest Pains Chest Pains Chest Pains Chest Pains Chest Pains Chidney Stones Kidney Stones Kidney Disorders Kidney Disorders Chidney Disorders Chest Pain Change Bladder Infection Chess of Bladder Core Chess of Bladder Core Chess of Bladder Core Chess of Appetite Chest Pains	Past Present  Headaches  Neck Pain  Upper Back Pain  Chest Pains  Mid Back Pain  Chid Pains  Mid Pains  Chest Pains  Chest Pains  Mid Pains  Chest Pains  Mid Pains  Chest Pains  Mid Pains  Chest Pains  Mid Pains  Chest Pains  Chest Pains  Chest Pains  Mid Pains  Chest	Headaches	Present Past Present Past Present  Headaches O High Blood Pressure O Diabetes  Neck Pain O Heart Attack O Excessiv  Upper Back Pain O Chest Pains O Frequent  Mid Back Pain O Stroke  Low Back Pain O Angina O Smoking  Shoulder Pain O Kidney Stones  Elbow/Upper Arm Pain O Kidney Stones  Wrist Pain O Bladder Infection O Depressi  Hand Pain O Painful Urination O Systemic  Hip/Upper Leg Pain O Less of Bladder Control O Epilepsy  Knee/Lower Leg Pain O Abommal Weight Gain/Loss  Make/Foot Pain O Abommal Weight Gain/Loss  Jaw Pain O Abdominal Pain O Birth Cor  Arthritis O Ulcer O Hormona  Arthritis O Hepatitis O Pregnanc  Rheumatoid Arthritis O Liver/Gall Bladder Disorder  O Visual Disturbances O Ashtma  O Dizziness O Chronic Sinusitis  Tet an immediate family member has had any of the following:  Ite if an immediate family member has had any of the following:  Interest of the procedures you have had and times you have been hospitalized:  Signature Date	Present Past Present Past Present Past Present  Headaches O High Blood Pressure O Diabetes  Neck Pain O Heart Attack De Excessive Thirst  Upper Back Pain O Chest Pains O Frequent Urination  Mid Back Pain O Stroke  Low Back Pain O Angina Drug/Alcohol Depende  Shoulder Pain O Kidney Stones Elbow/Upper Arm Pain O Kidney Disorders O Allergies Elbow/Upper Arm Pain O Bladder Infection O Depression  Hand Pain O Painful Urination O Systemic Lupus  Hip/Upper Leg Pain O Less of Bladder Control Depende  Knee/Lower Leg Pain O Abdominal Pain O Abdominal Pain O Abdominal Pain O Birth Control Pills  Jaw Pain O Abdominal Pain O Birth Control Pills  Joint Swelling/Stiffness O Ulcer O Hormonal Replacemer  Arthritis O Hepatitis O Pregnancy  Rheumatoid Arthritis O Liver/Gall Bladder Disorder  Muscular Incoordination O Tumor O Pregnancy  Muscular Incoordination O Tumor O Dizziness  Tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has had any of the following:  tel fan Immediate family member has ha