Walsh Family Chiropractic Center | 1309 Jamestown Road, Suite 102 | Williamsburg, VA 23185| 757.220.4917 | 757.220.5884, fax

Confidential Patient Data

If you need any assistance completing this form, please ask the receptionist.

Legal First Name: _____ Middle Name _____ Last Name: _____

Nickname: _____ Spouse's Name (if applicable) _____

SSN: _____ ❍ Female ❍ Male Date of Birth: ____/____/____ E-Mail Address: _____

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

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Preferred method of communication for patient reminders: ❍ Email ❍ Phone ❍Mail

Employment Status: ❍ Full-Time ❍ Part-Time ❍ Retired ❍ Un-Employed ❍ Child ❍ Disabled ❍ Homemaker

Occupation Type: _____ Employer's Name: _____

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated

*Race: ❍ American Indian or Alaska Native ❍ Asian ❍ Black or African American ❍White (Caucasian)
❍ Native Hawaiian or Pacific Islander ❍ Other ❍ I Decline to Answer

Preferred Language: _____

*Ethnicity: ❍ Hispanic or Latino ❍ Not Hispanic or Latino ❍ I Decline to Answer

How did you hear about us? ❍ Friend/Family Member – Name: _____ ❍ Yellow Pages ❍ Mail
❍ Clinic/Primary Care Physician – Name: _____ ❍ Other: _____

Primary Care Physician _____ Phone (____) _____

Emergency Contact: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Walsh Chiropractic Center, P.C., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Printed Name: _____ Signature: _____ Date: _____

Informed Consent

I hereby request and consent to the performance of a chiropractic evaluation, chiropractic adjustments, and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Walsh and/or anyone working in this clinic authorized by Dr. Walsh.

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

Printed Name: _____ Signature: _____ Date: _____

** CMS requires providers to report both race and ethnicity.*

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Financial Policy

Patient First Name: _____ **Last Name:** _____ **SSN** _____

Person Responsible for Bill

❍ self *(if "self," you do not have to complete the remainder of the information in this shaded box)*

❍ another individual

_____ Date of Birth: ____/____/____
Last Name First Name Middle Name

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

Relationship to Patient: _____ Home Phone: (____) _____ SSN _____

Is this person a patient here? _____ Employed By: _____ Work Phone: (____) _____

Business Mailing Address: _____ City: _____ State: _____ Zip _____

Payment for Services will be made primarily by:

❍ Cash ❍ Check ❍ Credit Card ❍ Health Insurance ❍ Automobile Insurance ❍ Worker's Compensation

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. You will have 30 days upon receipt of a Statement of Account to pay in full without penalty. After 30 days you will begin to accrue interest at 14.4% APR.
3. After 90 days, delinquent accounts will be forwarded to a collection agency. At this time all costs associated with collections will become the patient's responsibility. In addition, if you, the patient, choose to acquire an attorney, you, the patient, will be responsible for all attorney fees.
4. A $10.00 processing fee will be charged for all returned checks.
5. This office may make payment plans/arrangements on an individual basis. Any such plan or arrangement will be discussed after your report of findings.
    a. If you enter into a payment agreement and discontinue care before the plan is completed, you will only be responsible for those services that have been provided to date. If the remaining balance is greater than that amount paid to date (due to the nature of the payment plan) the remaining account balance will be due. Should there be a credit, the credit will be refunded to you. If insurance is involved, refunds will be made after all insurance claims have been settled.
6. If you have questions concerning this or any other matter, please speak with the receptionist prior to seeing the doctor.

It is understood this is a highly specialized, unique and effective method of care. Knowing that 70% of the doctor's knowledge, expertise, time and technical equipment will be utilized in the first three weeks of patient's care; 20% in the second phase, and 10% in the final phase of care.

I have read and understand the Financial Policy.

_____ _____
Patient's Signature Date

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NeuroIntegration Intake Form

Patient Name:_____ **Date:** _____

Tell us more about your needs and desires regarding brain health.
How can we help? What are you hoping to address or achieve through our NeuroIntegration Program?

_____

_____

_____

Health Information

1. Overall Health	On a scale of 1-10, how would you rate your current health? (1 being the worst, 5 being average, 10 being the best)	1 2 3 4 5 6 7 8 9 10
2. Sleep	Rate the quality of sleep you usually get in the past month. At what time do you go to bed? At what time do you rise in the morning?	1 2 3 4 5 6 7 8 9 10 _____am/pm _____am/pm
	Are you able to sleep through the night? If NO, please describe: _____	☐ Yes ☐ No
	Are you able to fall asleep easily most nights? If NO, please describe: _____	☐ Yes ☐ No
	Do you wake refreshed? If YES, please describe any exceptions: _____	☐ Yes ☐ No
3. Head or Neck Injury	Have you ever injured your head or neck?	☐ Yes ☐ No
	Ever had a concussion?	☐ Yes ☐ No
	If yes, have you suffered more than one concussion?	☐ Yes ☐ No
	Have you ever been in an auto, motorcycle or bicycle accident?	☐ Yes ☐ No
	Have you ever had a traumatic brain injury?	☐ Yes ☐ No
	Are you currently receiving care for this/these injuries?	☐ Yes ☐ No
	Please describe your head or neck injuries using the reverse side of this page, thinking back over the years. Please consider the childhood and teen years, as well as adulthood, including home life, sports, accidents, slips/falls, etc.	
4. Chronic Health Problems	Do you have any chronic health problems?	☐ Yes ☐ No
	If YES, please list any chronic medical problems or brain health issues you have on the back side of this form.	
5. Hormones	Are you concerned that hormonal imbalances that may be contributing to your condition?	☐ Yes ☐ No
6. Moods & Emotions	How would you describe your general emotional state? (A brief sentence or short phrase of 3-4 words is fine) _____	

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NeuroIntegration Intake Form

7. Medication, Supplements & Vitamins	If you haven't previously listed these on our intake form, please provide a list here including name, dose, frequency and for what symptom you are taking each. Feel free to use the other side.	
	Medications	**Nutrition Supplements/Vitamins**
	Any known medication allergies? If YES, please list any medication allergies you may have: _____ _____	☐ Yes ☐ No
8. Substances	Do you currently use psychoactive drugs, medications or alcohol to pick yourself up or calm yourself down?	☐ Yes ☐ No
	Have you ever used psychoactive drugs, medications or alcohol in the past to pick yourself up or calm yourself?	☐ Yes ☐ No
	Are you currently a smoker?	☐ Yes ☐ No
	Do you consider your current use of tobacco, alcohol or street drugs a problem? If yes on any of these substances, circle those currently taking.	☐ Yes ☐ No
	Do you feel depressed or anxious at the present time?	Depressed Anxious Neither
	Have you suffered from depression or anxiety in the past? Circle condition if yes.	☐ Yes ☐ No
9. Attention & Learning	Any history of learning difficulties?	☐ Yes ☐ No
	Any history of memory problems?	☐ Yes ☐ No
	Any history of ADD/ADHD? In childhood? Adulthood? (please circle)	☐ Yes ☐ No
10. Other Conditions	Any history of other psychiatric conditions in yourself, such as schizophrenia, bi-polar disorder , psychosis?	☐ Yes ☐ No
	Any history of other psychiatric conditions in family members, such as Schizophrenia, bi-polar, psychosis?	☐ Yes ☐ No
11. Counseling & Psychotherapy	Are you currently working with a psychiatrist, therapist, counselor or clergy in matters regarding your mental health? If yes, please list name/names: _____	☐ Yes ☐ No
12. Seizures or Light Sensitivity	Are you, or have you ever been, sensitive to lights or strobe lights, had or been diagnosed with migraines or epileptic seizures?	☐ Yes ☐ No
Is there anything that you would like to add? _____ _____		

Parent or Guardian of Minor, please complete this section:

Parent/Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Do you live with the patient: Yes No Phone: _____