WELCOME TO ROSELLE CENTER FOR HEALING

Today's Date ________________ **Please Print:**

PERSONAL INFORMATION

FIRST NAME: ________________________ MIDDLE/ M.I. _____________/ _____ LAST NAME _________________________

HOME PHONE: ____________________ MOBILE NUMBER: _____________________ WORK NUMBER___________________

ADDRESS: _____________________________________CITY: ____________ STATE: _________ ZIP CODE________________

AGE: ______ DATE OF BIRTH: ________________ GENDER ❑ Male ❑ Female ❑ Unspecified

MARITAL STATUS (*check one*) ❑ Single ❑ Married ❑ Other: ___________ CHILDREN? __________

OCCUPATION: ____ EMPLOYER: ____

ADDRESS: ____ WORK NUMBER: __________________________

NAME OF SPOUSE: ____________________ OCCUPATION: ____________________ WORK NUMBER: ____________________

EMERGENCY CONTACT: ____ PHONE NUMBER: _______________________

HOW DID YOU HEAR ABOUT US? ____ (Please write in name of person or event)

HOME EMAIL ____ **OTHER EMAIL** _____________________________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(Check one)* ❑ Home ❑ Other

Contact Method *(check one)*

❑ Primary Phone ❑ Mobile Phone ❑ Home Email ❑ Other Email

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Asian ❑ Asian Indian ❑ Chinese ❑ Filipino
❑ Japanese ❑ Korean ❑ Vietnamese ❑ Native Hawaiian or another Pacific
Island
❑Samoan ❑ Guamanian or Chamorro ❑Other________❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese ❑ French ❑ German
❑ Tagalog ❑ Vietnamese ❑ Italian ❑ Korean ❑ Russian ❑ Polish
❑ Arabic ❑ Portuguese ❑ Japanese ❑ French Creole ❑ Greek ❑ Hindi
❑ Persian ❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

HEALTH HISTORY

PURPOSE OF THIS APPOINTMENT: ______________________________

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? YES________ NO ________ COMES AND GOES _________

HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD? ______________________________

WHAT POSITIONS OR ACTIVITIES AFFECT YOUR CONDITION? ______________________________

WHAT DO YOU BELIEVE IS WRONG WITH YOU? ______________________________

OTHER DOCTORS SEEN FOR THIS CONDITION: ______________________________

DO YOU TAKE ANY VITAMINS? YES___ NO ___ DO YOU THINK YOU MIGHT NEED VITAMINS OR MINERALS? YES_____ NO ______

ARE YOU WEARING HEEL LIFTS? _____, SOLE LIFTS_____ INNER SOLES _____ OR ARCH SUPPORTS______

DO YOU HAVE TINGLING OR NUMBNESS IN: SHOULDERS___ARMS___ELBOWS___HANDS___HIPS____LEGS___KNEES___ FEET____

SERIOUS ILLNESS? ______________________________

WHAT OPERATIONS HAVE YOU HAD? ______________________________

DATE OF LAST PHYSICAL: ______________________________ FEMALE: ARE YOUR PREGNANT YES_____ NO _____

HAVE YOU EVER BEEN UNDER CHIROPRACTIC/ ACUPUNCTURE CARE? YES _____ NO _____ DOCTOR'S NAME: ____________________

ADDITIONAL INFORMATION YOU WOULD LIKE TO TELL US: ______________________________

____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

	Start Date		Start Date
1)		5)	
2)		6)	
3)		7)	
4)		8)	

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ______________________________ 3) ______________________________

2) ______________________________ 4) ______________________________

8500 Executive Park Avenue, Suite 300 Fairfax, VA 22031 Phone: (703) 698-7117 Fax: (703) 698-5729 Email: Rosellecare@gmail.com

Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No If yes, describe:________________

____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ____

Have you had an X-ray or CT scan or MRI of your spine in the past 12 months? ❑ Yes ❑ No

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR? YES____ NO ____ DESCRIBE______

HAVE YOU EVER SUFFERED FROM:

Female

- ☐ Menstrual Irregularity
- ☐ Cramps
- ☐ Menopause
- ☐ Hot Flashes
- ☐ Lumps in Breast

Male

- ☐ Prostate Problems
- ☐ Male Menopause
- ☐ ED

Structural Problems

- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Numbness
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Joint Inflammation
- ☐ Neck Pain

Vascular Disorders

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Irregular Heart Beat
- ☐ Anemia
- ☐ Stroke
- ☐ Bruise Easily
- ☐ Varicose Veins
- ☐

Upper Respiratory

- ☐ Difficult Breathing
- ☐ Hay Fever
- ☐ Asthma
- ☐ Colds
- ☐ Sinus Infections
- ☐ Allergies

Digestive & Bowel Disorders

- ☐ Difficult Digestion
- ☐ Nausea/ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Acid Reflux

Diseases

- ☐ Immune Deficiency Syndrome
- ☐ Cancer
- ☐ Covid
- ☐ Thyroid
- ☐ Lyme
- ☐ Epstein Barr
- ☐ Lupus

Other

- ☐ Headaches/ Migraines
- ☐ Sleep Disturbance
- ☐ Dizziness
- ☐ Fatigue
- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ ______________
- ☐ ______________
- ☐ ______________
- ☐ ______________
- ☐ ______________

CHECK FREQUENCY

HABITS	HEAVY	MODERATE	LIGHT	NONE		HABITS	HEAVY	MODERATE	LIGHT	NONE
Dairy						**Appetite**				
Alcohol						**Sodas**				
Recreational Drugs						**Black Tea**				
Exercise						**Sweets**				
Coffee						**Water**				
Sleep						**Tobacco**				

TO BE PERFORMED BY STAFF:

HEIGHT: ______ INCHES ______ WEIGHT _______LBS BP: SITTING ______/_____ LYING ______/______ STANDING ______/______

Oxygen _________ Pulse Rate__________ PH: ____________ Zinc: __________

Information taken by:____________________

General Consent to Treat – Adult

I authorize ROSELLE CENTER FOR HEALING, their associates, assistants, and other qualified medical personnel to treat me and to recommend and/or order laboratory tests or other specialized tests as indicated for diagnosis for my medical condition.

Print Name: ___________________________ Patient's/Guardian Signature: ______________________ Date: _______________

Witness: _____________________________ Signature: _______________ ____________________ Date: _______________
Print Name-

MEDICARE PATIENTS:

Do you currently have Medicare Part B _____ Please be advised that it is your responsibility to inform this office if and when you become eligible for benefits.

Medicare will only cover Spinal Manipulation in our office, CPT code 98940, 98941 and it has to be for" Acute Active Care". This means that you require weekly care for a condition that is currently causing you pain or discomfort. They will not cover you for "Chronic" conditions. They may consider 12-20 visits at their discretion based on your diagnosis. If you have Secondary Insurance, Medicare is responsible to forward your charges after they have processed them. We cannot submit to your secondary, it must go to Medicare first.

OTHER FINANCIAL CONSIDERATIONS

Please inform your doctor if your condition is due to a Personal Injury or Work-Related Injury. Yes _____ No _____

PAYMENT IS EXPECTED IN FULL AT TIME OF VISIT:

NAME OF PERSON RESPONSIBLE FOR PAYMENT: ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare some reports and forms to assist me in making collections from the insurance company. I clearly understand and agree ***that all services rendered me are charged directly to me and that I am personally responsible for payment.*** I also understand that balances that are 90 days or older will accumulate 9.5% interest. I 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 further understand that if I fail to pay this bill and it is turned over to an attorney or (collection agency) for collections that I will be responsible for all legal fees, court fees and collection agency fees.

PATIENTS SIGNATURE: ______________________________________ DATE: ___________________________________

PARENT OR GUARDIAN
AUTHORIZING CARE: ____ DATE: ___________________________________