Rockville chiropractic & sports Care
121 Congressional Lane Suites 600
Rockville, MD 20852
Tel) 301-822-4363 Fax) 301-822-4407
www.rockvillechirosportscare.com

Welcome to Rockville Chiropractic & Sports Care

Patient Information

Name________________________ Birth Date__________ Age_______ ☐ Male ☐ Female

Address______________________________ City, State, Zip code____________________

Cell #____________________ Home #_________________ Work #__________________

Email ________________________________ Marital Status: ☐ Single ☐ Married ☐ Divorce

Occupation _________________________________ How long? ______________________

Employer___________________________ Social Security # __________-_______-__________

Emergency Contact__________________ Relation________Phone#____________________

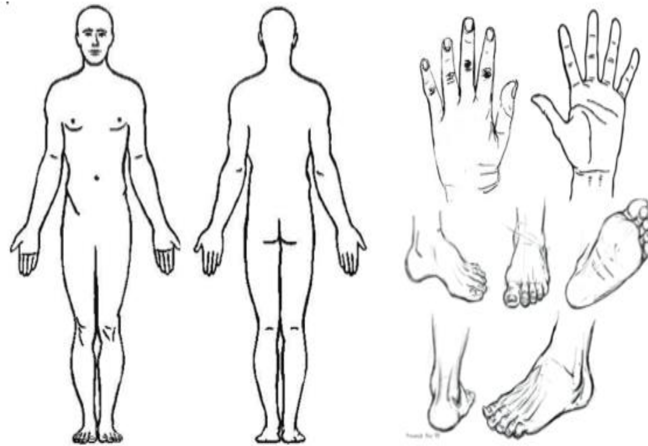
How did you hear about us? ____

Purpose For today's visit

Reason for visit ____

Is this visit related to an auto accident or work related injuries? ☐ Yes ☐ No Date____________

Indicate Area(s) showing the type of Discomfort you have using provided markings



Aching ○
Dull Pain ////
Stabbing ✕
Tingling ✱
Numbness ◇
Pins & Needles △
Burning ☐

(No pain) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 (Worst)

How long have you had this symptom? _________ Have you had this symptom before? _________

What caused this symptom occur? ____________________________________ ☐ Don't know

What makes it **better**? ____

What makes it **Worse**? ____

Have you been treated for this? ☐ Yes ☐ NO If yes, explain_____________________________

Have you had any Xray, MRI, CT, etc. for this condition? _________________________________

Have you seen a chiropractor before? ☐ Yes ☐ No If yes, explain__________________________

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Review of Systems (Do you have any of following? Check all that apply)

ENDOCRINE			SKIN CONDITIONS			HEMATOLOGIC			CARDIOVASCULAR		
☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current
Thyroid			Rash or Itching			Hepatitis			Poor Circulation		
Diabetes			Change in skin color			Blood Clots			High Blood Pressure		
Hair Loss			Lumps / Masses			Cancer			High Cholesterol		
Menopause			Varicose Veins			Easily Bruising			Heart Disease		
Appetite Change						Bleeding			Heart Attack		
CONSTITUTIONAL			**NEUROLOGIC**			**GASTROINTESTINAL**			Aortic Aneurism		
☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current	Pace Maker		
Weight Loss/Gain			Stroke			Gall Bladder			Jaw Pain		
Low Energy			Seizures			Bowel Problems			Irregular Heartbeat		
Chills/Fever			Head Injury			Diarrhea			Swelling of Legs		
Night Sweats			Brain Aneurysm			Constipation			Chest Pain		
PSYCHIATRIC			Pinched Nerves			Liver Problems			**EYES**		
☐ None of below	past	current	Parkinson's			Ulcers			☐ None of below	past	current
Depression/Anxiety			Carpal Tunnel			Nausea/Vomiting			Glaucoma		
Stress			Vertigo			Bloody Stool			Double Vision		
Memory Loss									Blurred Vision		
MUSCULOSKELETAL			**EAR/NOSE/THROAT**			**GENITOURINARY**			**RESPIRATORY**		
☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current	☐ None of below	past	current
Gout			Difficulty Swallowing			Kidney Disease			Asthma		
Arthritis			Dizziness			Kidney Stones			Tuberculosis		
Muscle Weakness			Hearing Loss			Frequent Urination			Short of Breath		
Osteoporosis			Nosebleeds			Burning Urination			Pneumonia		
Broken Bones			Bleeding Gums			Blood in Urine			Frequent Cough		
Joint Replacement											

Please list other conditions not listed above____

List any surgeries____

Have you had an auto accident before? ______________________When ____________________

Family history

Anyone of your family members are being treated for ______________________________

____

Social History

Alcohol use ☐ Daily ☐ Weekly ☐ Monthly How much? ______________________________

Tobacco use ☐ Daily ☐ Weekly ☐ Monthly How much? ______________________________

Exercising ☐ Daily ☐ Weekly ☐ Monthly How much? ______________________________

Activities of Daily living

What is your major stress in life? ____

How much sleep do you average per night? ______________________________________

What is you preferred sleeping position? ____

Eating habits: ☐ Skip breakfast ☐ Two Meals a day ☐ Three meals a day

In addition to the main reason for your visit today, what additional health goals do you have?