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? _____

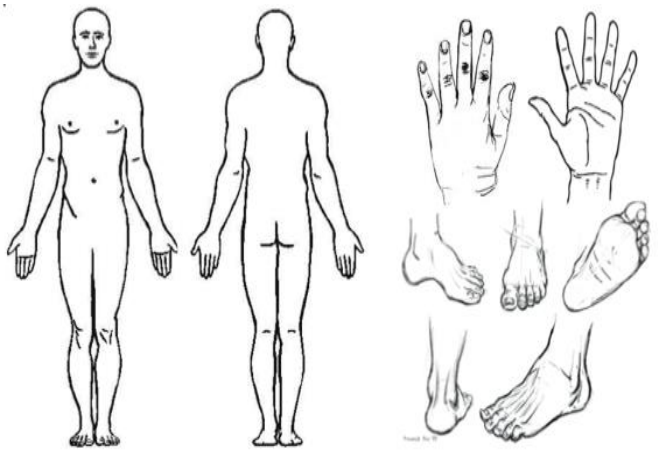
Purpose For today's visit

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?

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Acknowledgements

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health, I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge **I am not pregnant**. Date of last menstrual period _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as extension of my care in clinic

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and I am responsible for Insurance **Pre-Verification** and any **non-covered services** I receive (Deductibles, Co-Insurance, Co-pay etc.) Should any balances remain unpaid, the office reserves the right to send the balances to collections. The 30~35% collection fee added from outstanding balance will be entirely the patient's responsibility. (UHC/Cigna are out of network)

Initials _____ To the best of ability, the information I have supplied is complete and truthful; I have not misrepresented the presence, severity or cause of my health concern.

Initials _____ Our cancellation fee is **$40** for missed appointment without letting us know or last minute cancellations **24 hours before appointment time.**

Initials _____ There will be a $30 service charge on all returned checks.

Initials _____ I understand that the charges not covered by my insurance company such as Initial Exam ($100) and Physical Therapy ($40 using only Medicare, $30 depending on Secondary insurance) as well as applicable deductibles are my responsibility. **(MEDICARE PATIENTS ONLY)**

Patient / Guardian's name _____

Signature _____ Date _____

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Patient Information and Consent for Dry Needling

Myofascial trigger points and tender points which appear in soft tissue, and are painful sites, reflect abnormal nervous system activity associated with many neuro-musculo-skeletal conditions that are treated in our office. The procedure known as Dry Needling is an important tool for diagnosing, treating and monitoring changes in myofascial trigger/tender points. During this procedure, a sterile, very thin, solid filament needle is inserted into tissue that may be associated with one or a number of your complaints. One or a number of needles may be used, and the procedure may be performed more than one office visit. The number of needles and the frequency of the procedure will depend entirely on your condition at each office visit. There is little to no pain with this procedure. There is little to no bleeding with this procedure. While an infection is unlikely with this procedure, there are small risks of infections, (caused by penetration of the skin) such as, fainting, soreness, or pneumothorax (lung puncture). If you have a fear of needles, a genetic bleeding disorder, a history of a blood disorder that can be transmitted to another person, are regularly taking any blood thinning medication (for example, Coumadin or Warfarin), or are regularly taking any pain relievers containing ibuprofen, NSAIDS, aspirin or acetaminophen (for example, Tylenol, Advil, Aleve, or Bufferin), please inform us by placing a check mark as indicated below:

___ I have a fear of needles.

___ I have a genetic bleeding disorder. Please specify: _____

___ I have a history of a blood disorder that can be transmitted to another person. Please specify:

_____

___ I am regularly taking blood thinning (anti-coagulation) medication. Please specify:

_____

___ I am regularly taking pain relievers. Please specify:

I have read this Patient Information and Consent carefully, ***I understand this procedure is not acupuncture*** and I have had an opportunity to ask questions and obtain any desired clarification, and I consent to having the procedure of Dry Needling performed on me. I give permission to have the treated region(s) photographed for records/educational purposes.

Patient Name (Please print): _____

Signature:_____ Date_____

If patient is less than 18 years of age parent or legal guardian must sign.

Name of Parent/Legal Guardian (Please print): _____

Signature _____ Date_____