Potomac Sports Chiropractic
21495 Ridgetop Circle, Ste 106
Sterling, VA 20166
Phone: (703) 723-9355
Website
Facebook

Chiropractic Patient Intake Form

Name:_____
(Last) *(First)* *(Initial)*

What would you like to be called? _____ Sex: ❑ Male ❑ Female

Marital Status:_____# of Children:_____

Date of Birth:_____/_____/_____ Age:_____ Height:_____ft._____in. Weight:_____lbs.

Home Address:_____ City:_____

State:_____ Zip Code:_____

Phone #:_____Work:_____Cell:_____

Email address:_____

Employer:_____ Occupation:_____

In case of emergency, who should we notify/phone?_____

Your Family Physician/phone:_____

Have you ever received Chiropractic Care? ❑ No ❑ YES

If **YES**, name of previous Chiropractic Physician(s):_____

How did you hear about Potomac Sports Chiropractic?

❑ Doctor referral: _____
❑ Family/Friends/Co-Worker:_____
❑ Your Health Insurance Company
❑ Facebook
❑ Google Search
❑ Physical Therapist referral:_____
❑ Coach/Personal Trainer:_____
❑ Yelp
❑ Others:_____

Privacy Notice (HIPAA)
Potomac Sports Chiropractic is committed to protecting your medical information. We maintain a record of the care and services you receive for use in your ongoing care and treatment. A copy of the Potomac Sports Chiropractic Privacy Policy is available upon request. _____
(Initials)

Financial Policy
Our policy requires payment in full for all services rendered at time of visit, unless other arrangements have been made. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. Patients are responsible for knowing their insurance benefits. My office will only bill out to your primary insurance company. _____
(Initials)

Late Cancellation/Reschedule Fee
We require a 24-hour notice for all appointment cancellations or rescheduling. A $50 fee may be charged if notice is less than 24 hours. _____
(Initials)

Signature:_____ Today's Date:_____/_____/___

Chief Complaints

- Reason for seeking care: *(Please provide a description)*

_____

_____

- When did this begin:_____/____/_____
- What's the **nature** of your condition?
  - ❑ New/Acute
  - ❑ On-going/Unresolved/Chronic
  - ❑ Sports-related
  - ❑ Car accident related
  - ❑ Work related
  - ❑ Post-surgical rehab:_____
  - ❑ Others:_____
- How often is it troublesome?
  - ❑ Everyday
  - ❑ Several times a week
  - ❑ Several times a month
  - ❑ Other, please explain _____
- Is the condition getting:
  - ❑ Worse
  - ❑ Consistent/Constant
  - ❑ Same
  - ❑ Recurring/Comes & goes
  - ❑ Better
- How has this condition interfered with your daily routine? re: play, work, sleep etc.?

_____

_____

- Is there a particular **time of day** when your condition is worse?
  - ❑ Morning
  - ❑ During the night
  - ❑ Afternoon
  - ❑ After long periods of activity
  - ❑ Evening
  - ❑ During specific activities: _____
- How would you describe the pain that you are experiencing?
  - ❑ Sharp
  - ❑ Intermittent
  - ❑ Dull/Ache
  - ❑ Tingling
  - ❑ Numbness
  - ❑ Burning
  - ❑ Shooting
  - ❑ Radiating pain
  - ❑Other_____
- What aggravates your condition?

_____

_____

_____

- What types of treatment have you received for this condition? *(Please list.)*
  - ❑ Icing
  - ❑ Heat
  - ❑ Self-medicate
  - ❑ Physical Therapy
  - ❑ Prescription medications
  - ❑ Reflexology
  - ❑ Chiropractic
  - ❑ Cortisone Shot
  - ❑ Massage
  - ❑ PRP Injections
  - ❑ Acupuncture
  - ❑ Surgery
  - ❑ Dry Needling
  - ❑ Others:_____
- Please provide the names of other doctors or practitioners and their specialty that you have seen for this condition.

_____

_____

_____

- Do you have a **history** of similar conditions?

_____

_____

_____

- What was the duration and frequency of previous treatment for this condition?

_____

_____

- What were the **results** of previous treatments:
  - ❑ Poor
  - ❑ Fair
  - ❑ Good
  - ❑ Excellent
  - ❑ Other, please explain _____
- Have you had **laboratory** or **diagnostic test** (e.g. x-ray, MRI, CT) performed that is related to your current complaint?

_____

_____

- **Any other relevant information pertaining to your condition?**

_____

_____

_____

_____

- **Secondary Complaints:** What other conditions are you seeking treatment for?

_____

_____

- **Medications or Supplements** - Are you currently on any medications or supplements?
  ❑ NO ❑ YES *(List all)*

_____

_____

_____

_____

_____

_____

- **Surgeries** - Have you previously had any surgeries? ❑ NO ❑ YES

_____

_____

_____

_____

_____

_____

- **Is there anything else you want to share about your health history?**

_____

_____

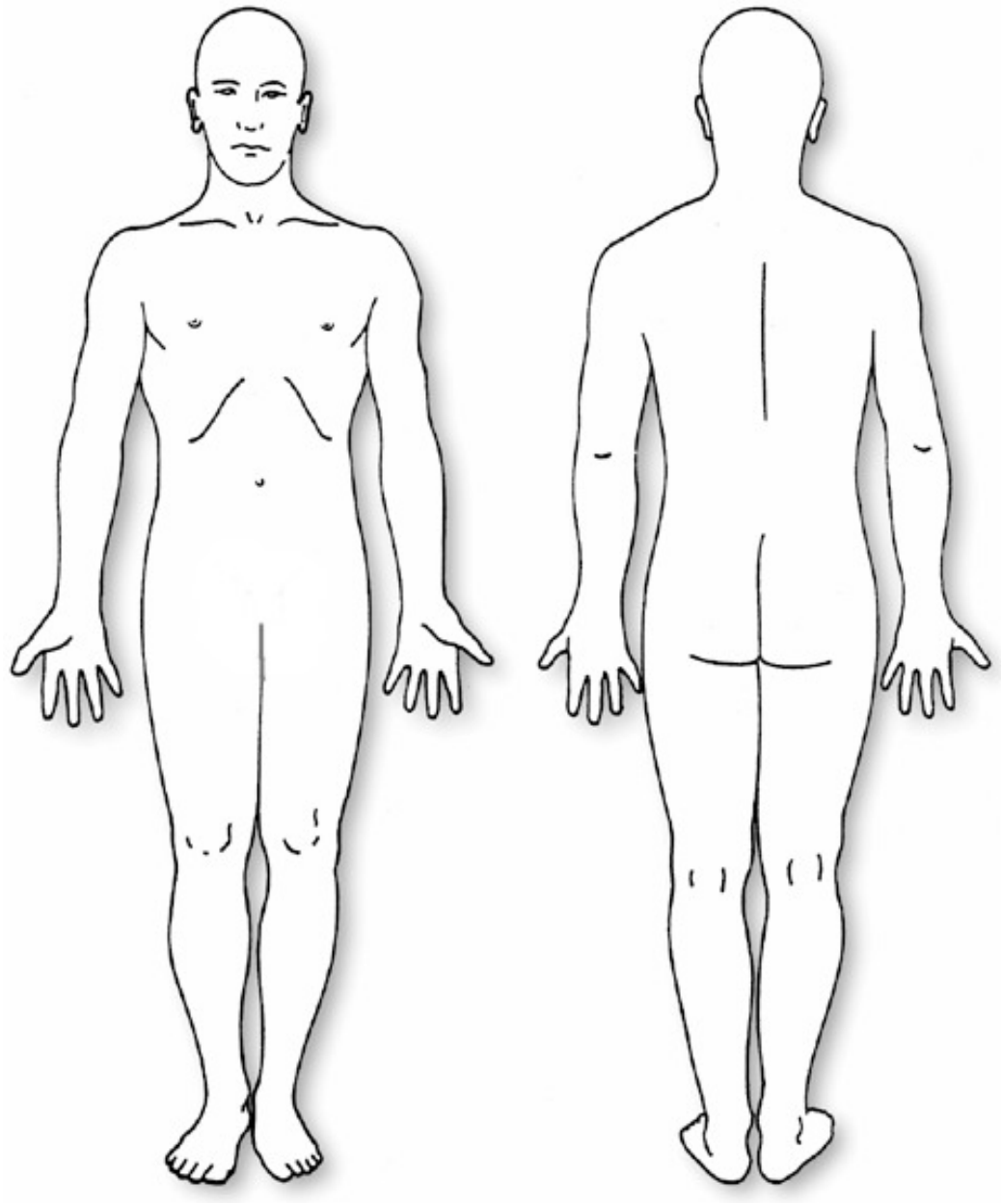
_____

_____

Pain Diagram

(Please number the areas where you are experiencing pain or discomfort, according to the following pain scale.)

Number Listing	Amount of pain
0	No pain or discomfort.
1, 2, 3	Pain or discomfort is an annoyance.
4, 5, 6	Pain or discomfort interferes with performing certain activities.
7, 8, 9	Pain or discomfort prevents me from performing certain activities.
10	Pain or discomfort sends me to the emergency room.



General Systems Review (Please select any items that relate to your condition or body)

Respiratory

Past Present

- ☐ ☐ Allergies
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Cough
- ☐ ☐ Emphysema
- ☐ ☐ Frequent Colds
- ☐ ☐ Hay fever
- ☐ ☐ Pneumonia
- ☐ ☐ Smoker
- ☐ ☐ Tuberculosis

Skin

Past Present

- ☐ ☐ Acne Problems
- ☐ ☐ Dermatitis
- ☐ ☐ Eczema
- ☐ ☐ Fungal Infection
- ☐ ☐ Herpes
- ☐ ☐ Polyps
- ☐ ☐ Psoriasis
- ☐ ☐ Shingles
- ☐ ☐ Botox Injection

Vision

Past Present

- ☐ ☐ Glaucoma
- ☐ ☐ Light Sensitivity
- ☐ ☐ Blurred Vision
- ☐ ☐ Cataracts
- ☐ ☐ Double Vision
- ☐ ☐ Dyslexia

Cardiovascular

Past Present

- ☐ ☐ Angina
- ☐ ☐ Arrhythmia's
- ☐ ☐ Arteriosclerosis
- ☐ ☐ Blood Clots
- ☐ ☐ Chest pain
- ☐ ☐ Hypertension
- ☐ ☐ Rheumatic
- ☐ ☐ Heart Attack
- ☐ ☐ CHF
- ☐ ☐ High Cholesterol

Head

Past Present

- ☐ ☐ Insomnia
- ☐ ☐ Learning Problem
- ☐ ☐ Memory Problem
- ☐ ☐ Mental Illness

Gastro-intestinal

Past Present

- ☐ ☐ Appendicitis
- ☐ ☐ Appetite loss
- ☐ ☐ Black Stool
- ☐ ☐ Blood in Stool
- ☐ ☐ Constipation
- ☐ ☐ Chron's
- ☐ ☐ Colitis
- ☐ ☐ Diarrhea
- ☐ ☐ Heart Burn
- ☐ ☐ Gall Bladder Problem
- ☐ ☐ IBS
- ☐ ☐ Stomach Cramps
- ☐ ☐ Ulcers

Urinary

Past Present

- ☐ ☐ Bladder infections
- ☐ ☐ Blood in Urine
- ☐ ☐ Incontinence
- ☐ ☐ Infections
- ☐ ☐ Kidney Stones
- ☐ ☐ Yeast Infection

Vascular

Past Present

- ☐ ☐ Anemia
- ☐ ☐ Easy Bleeding
- ☐ ☐ Hemorrhoids
- ☐ ☐ Raynaud's
- ☐ ☐ Thromophlebitis
- ☐ ☐ Transfusions
- ☐ ☐ Varicose Veins

Musculoskeletal

Past Present

- ☐ ☐ Disc Problems
- ☐ ☐ Fractures
- ☐ ☐ Gout
- ☐ ☐ Paralysis
- ☐ ☐ Osteoarthritis
- ☐ ☐ Osteopenia
- ☐ ☐ Osteoporosis
- ☐ ☐ Rheumatoid
- ☐ ☐ Scoliosis

Endocrine

Past Present

- ☐ ☐ Diabetic
- ☐ ☐ Hyperthyroid
- ☐ ☐ Hypothyroid
- ☐ ☐ Adrenal Problem

Others:_____

Female Reproductive

# of Pregnancy: _____

Past Present

- ☐ ☐ Pregnant Due Date:_____
- ☐ ☐ Fibroids
- ☐ ☐ PID
- ☐ ☐ Hysterectomy
- ☐ ☐ Menopause
- ☐ ☐ STD
- ☐ ☐ Fertility Problems

Male Reproductive

Past Present

- ☐ ☐ Impotence
- ☐ ☐ Testicular Pain
- ☐ ☐ Prostate Problem
- ☐ ☐ STD
- ☐ ☐ Urination Trouble

Neurological

Past Present

- ☐ ☐ Epilepsy
- ☐ ☐ Parkinson's
- ☐ ☐ Concussion
- ☐ ☐ Seizures
  - ☐ Alzheimer's
  - ☐ Multiple Sclerosis

Others

Past Present

- ☐ ☐ Alcoholic
- ☐ ☐ Cancer
- ☐ ☐ Chemotherapy
- ☐ ☐ Depression
- ☐ ☐ Hepatitis
- ☐ ☐ ADD/ADHD
  - ☐ AIDS
  - ☐ HIV Positive

Family History

- ☐ Arthritis
- ☐ Genetic Problems
- ☐ Auto immune condition
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Heart Attack
- ☐ Stroke
- ☐ Vascular Problems

Others:_____

Childhood Conditions

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid , Rheumatic Fever
- ☐ Recurrent Ear Infections
- ☐ Chronically Ill
- ☐ Asthma
- ☐ Allergies

Others:_____

Social History & Life Choices

I exercise…	❑ daily ❑ 5-6x/week ❑ 3-5x/week ❑ 1-2x/week ❑ infrequently
Average time spent exercising…	❑ >1 hour ❑ 1 hour ❑ ~30 min ❑ < 30 min. ❑ n/a
My stress level is…	❑ severe ❑ high ❑ moderate ❑ mild ❑ manageable
I smoke…	❑ no ❑ yes
I consume alcohol…	❑ too much ❑ daily ❑ weekly ❑ infrequently ❑ never
I consume caffeine…	❑ too much ❑ daily ❑ weekly ❑ infrequently ❑ never
I consider my general health to be…	❑ excellent ❑ very good ❑ good ❑ fair ❑ poor

CONSENT TO CARE

I give permission and authority to Potomac Sports Chiropractic doctors to provide care in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problems. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. The doctor will not provide specific healthcare if he/she is aware that such care may be contraindicated.

It is the responsibility of the patient to make it known or to learn through health care procedures what he/she may be suffering from; latent pathological defects, illnesses or deformities that would otherwise not come to the attention of the physician.

I have read and understand the foregoing CONSENT TO CARE and acknowledge that I have stated all conditions of which I am aware and this information is true and accurate. I will inform the healthcare provider of any changes in my status.

Signature: _____ Today's Date: ____/____/____
(Patient, Legal Guardian)

Printed Name: _____

Payment Options & Authorization Agreement
Potomac Sports Chiropractic, LLC

Name: _____

Please choose one of the following:

❑ **Option 1: Auto-Debit Virtual Terminal**

I will provide credit card information below. I authorize Potomac Sports Chiropractic, LLC (PSC) and its contracted practice management group and affiliates to initiate charges to the card indicated below. These charges will reflect payment for services, products, missed appointment/late cancellation fees. If the card I have provided below is lost, stolen or expires, it is my responsibility to contact PSC or its practice management group and provide an alternate form of payment. I acknowledge that email receipts for all services and products will be sent to the email address I have provided. Authorization for this option is to remain in effect until I provide a written request of its determination.

Card Type: ❑ VISA
❑ MasterCard
❑ Discover Card
Is this a HSA/HRA card? ❑ Yes
❑ No

Name on Card: _____

Card Number: _____

Card Expiration Date: _____/_____

(If card holder is different from the patient, please fill out the following)

Card holder's relationship to patient: _____

Card holder's signature: X_____

❑ **Option 2: Pay Online**

I will pay online for my services and products within 48 hours after my appointment. I will receive an email with a link to a website, with my account # and instructions for paying online.

❑ **Option 3: Pay by Phone**

I will pay by phone for the services and/or products within 48 hours after my appointment by calling (703) 723-9355, press "4".

Signature: X_____ Today's Date: _____/_____/_____
(Patient, Legal Guardian)