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? _____ Gender: ❑ Male ❑ Female

Marital Status:_____# of Children:_____

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

Home Address:_____ City:_____

State:_____ Zip Code:_____

Cell #:_____Work:_____Home:_____

Email address:_____

Employer:_____ Occupation:_____

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

Your Family Physician/phone:_____

How many chiropractors have you seen in the past? ❑ 0 ❑ 1-2 ❑ 3-5 ❑ 6+

Name of previous Chiropractic Physician(s):_____

How did you hear about Potomac Sports Chiropractic?

❑ Doctor /Physical Therapist: _____
❑ Family/Friends/Co-Worker:_
❑ Your Health Insurance Company

Online Search Engines: ❑ Googled ❑ Instagram ❑ Facebook ❑ Yelp ❑ A.R.T. website

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. _____
(Initials)

Payment
Our policy requires **payment in full within 24 hours** of the appointment, 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. _____
(Initials)

Insurance
If we are in-network with your insurance policy, fees are established through your insurance company at a contracted rate. Some procedures we provide may not be covered by your insurance. Patients are responsible for knowing their insurance benefits (copays, coinsurance, deductibles, fees for all other procedures not covered by your insurance plan). _____
(Initials)

Late Notice/Cancelation 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:

_____

_____

_____

- When did this begin:_____/_____/_____
- Have you had a **history** of similar conditions?
  ❑ NO ❑ YES *(explain)*

_____

_____

What's the **nature** of your condition?

- ❑ New/Acute
- ❑ On-going / Unresolved / Chronic
- ❑ Sports-related
- ❑ Car accident related
- ❑ Work related
- ❑ Post-surgery:_____

- **How often** is it troublesome?
  - ❑ Constant (~100% of the time)
  - ❑ Frequent (>75% of the time)
  - ❑ Intermittent (>50% of the time)
  - ❑ Occasional (>25% of the time)
- Is the condition getting:
  ❑ Better ❑ Same ❑ Worse
- How has this condition interfered with your daily life? *Eg: can't workout as hard; pain while sitting; interrupted sleep habits etc.?*

_____

_____

_____

- Is there a particular **time of day** when your condition is worse?
  - ❑ Morning
  - ❑ Afternoon
  - ❑ Evening
  - ❑ in the middle of the night
  - ❑ After long periods of activity
- How would you describe the pain?
  - ❑ Sharp
  - ❑ Dull/Ache
  - ❑ Numbness
  - ❑ Shooting
  - ❑ Intermittent
  - ❑ Tingling
  - ❑ Burning
  - ❑ Radiating pain
  - ❑ Other_____
- What is the one thing you do that triggers/ aggravates it?

_____

_____

_____

- What types of treatment have you received for this condition? *(Check all that applies)*
  - ❑ Icing
  - ❑ Prescription Pain-Med
  - ❑ Chiropractic
  - ❑ Massage
  - ❑ Acupuncture
  - ❑ Dry Needling
  - ❑ Heat
  - ❑ OTC- Pain Meds
  - ❑ Physical Therapy
  - ❑ Cortisone shot
  - ❑ PRP Injections
  - ❑ Surgery
  - ❑ Others:_____

_____

_____

- Please provide the names of other doctors or therapists whom you have seen for this condition.
  - ❑ GP/PCP/NP: _____
  - ❑ Ortho: _____
  - ❑ PT: _____
  - ❑ Chiro: _____
  - ❑ Others: _____
- What were the **results** of previous treatments:
  - ❑ Poor ❑ Fair
  - ❑ Good ❑ Excellent
  - ❑ Other, please explain _____
- Have you had **laboratory** or **diagnostic test** performed that is related to your current complaint?

	Description	*Date*
❑ X-Ray:	_____	_____
❑ MRI:	_____	_____
❑ CTscan:	_____	_____
❑ Bloodwork:	_____	_____

- **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)*

_____

_____

_____

_____

_____

_____

- Are you currently on taking **blood thinners**?
  ❑ NO ❑ YES
- **Surgeries** - Have you previously had any surgeries? ❑ NO ❑ YES

_____

_____

_____

_____

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

_____

_____

_____

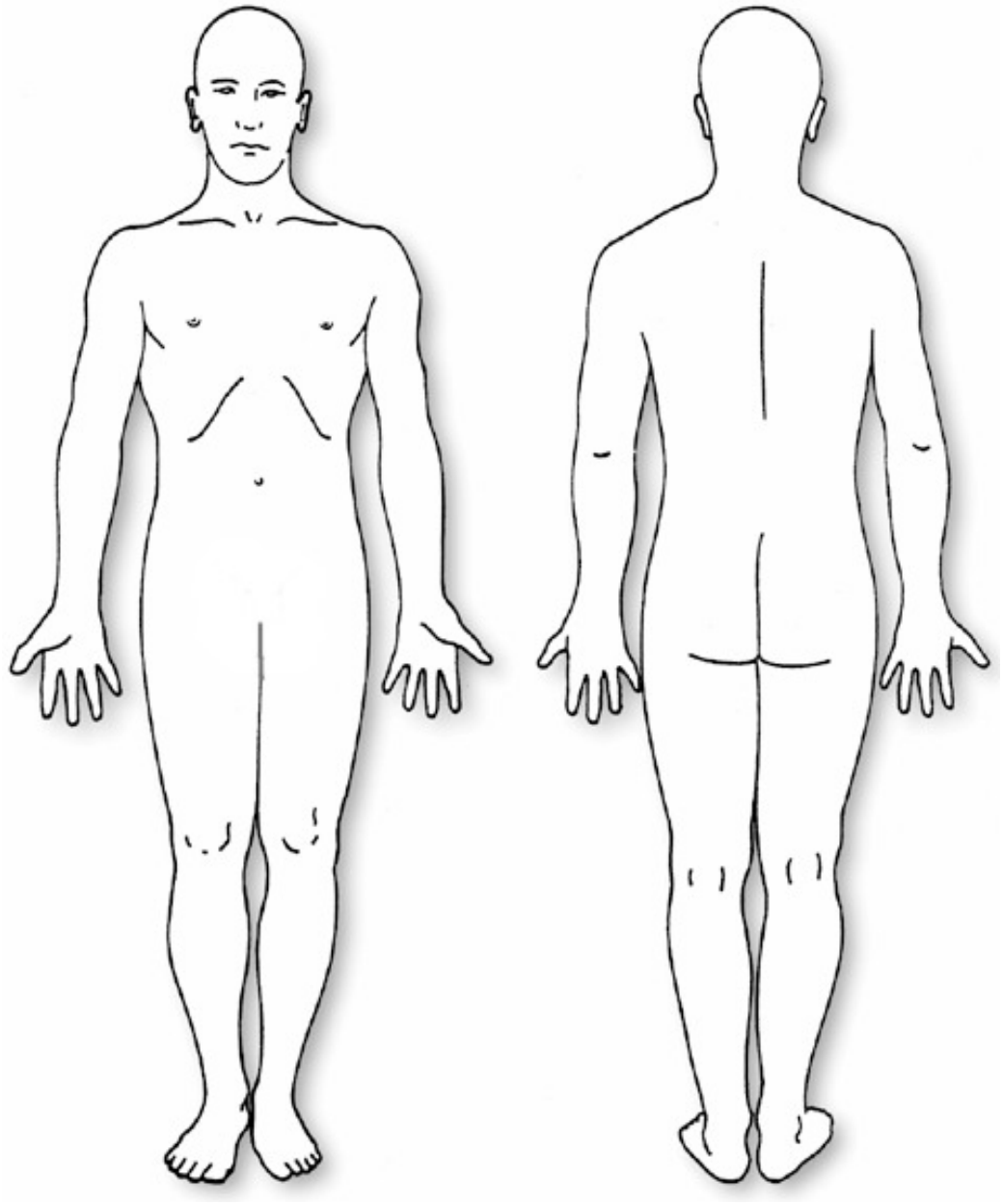
_____

- Are you seeking a specific therapy/modality?
  ❑ YES ❑ NO
  - ❑ Active Release Technique®
  - ❑ Graston Technique ®
  - ❑ Dry Needling

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 nearly 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
- ❑ ❑ 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

- ❑ ❑ Arrhythmia's
- ❑ ❑ Arteriosclerosis
- ❑ ❑ Blood Clots
- ❑ ❑ Angina Pectoralis
- ❑ ❑ Hypertension
- ❑ ❑ Heart Attack
- ❑ ❑ CHF
- ❑ ❑ High Cholesterol

Head

Past Present

- ❑ ❑ Insomnia
- ❑ ❑ Migraines
- ❑ ❑ Memory Problem
- ❑ ❑ Mental Illness

Gastro-intestinal

Past Present

- ❑ ❑ Appendicitis
- ❑ ❑ Black Stool
- ❑ ❑ Blood in Stool
- ❑ ❑ Constipation
- ❑ ❑ Chron's
- ❑ ❑ Ulcerative Colitis
- ❑ ❑ Gall Bladder Problem
- ❑ ❑ IBS

Urinary

Past Present

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

Vascular

Past Present

- ❑ ❑ Anemia
- ❑ ❑ Bleed Easily
- ❑ ❑ 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
- ❑ ❑ Fertility Problems
- ❑ ❑ Urination Trouble

Neurological

Past Present

- ❑ ❑ Epilepsy
- ❑ Parkinson's
- ❑ ❑ Concussion

# of concussions:_____

- ❑ ❑ 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
- ❑ Diphtheria
- ❑ Typhoid , Rheumatic Fever
- ❑ Recurrent Ear Infections
- ❑ Chronically Ill
- ❑ Asthma
- ❑ Allergies

Others:_____

Social History & Life Choices

I exercise…	❑ daily ❑ 5-6x/week ❑ 3-4x/week ❑ 1-2x/week ❑ infrequently
	❑ Running ❑ Cycling ❑ Swimming ❑ Pilates ❑ Yoga ❑ Tennis ❑ Weight Lifting ❑ Home Gym ❑ Gym Gym ❑ Peloton ❑ Tonal ❑ Golf ❑ Soul Cycle ❑ OTR ❑ Personal Trainer ❑ Hiking
Average weekly exercise time	❑ >20 hrs ❑ 15-10 hrs ❑ <10 hrs ❑ < 5 hrs ❑ <1 hr
My stress level is…	❑ severe ❑ high ❑ moderate ❑ mild ❑ manageable
I smoke…	❑ no ❑ yes
I consume alcohol…	❑ too much ❑ daily ❑ weekly ❑ infrequently ❑ never
Average weekly sleep time	❑ >60 hrs ❑ 50-60 hrs ❑ 40-50 hrs ❑ 35-40 hrs ❑ <1 hr
I consume caffeine…	❑ too much ❑ daily ❑ weekly ❑ infrequently ❑ never
I consider my general health to be…	❑ excellent ❑ very good ❑ good ❑ fair ❑ poor
My least healthiest habit is:	

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 procedure 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: Pay by Credit Card (Automated)**

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
❑ Discovery
- Is this a HSA/HRA card? ❑ No ❑ Yes

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 (Non-Automated)**

I will receive an email with a link to a website within 48 hours of my visit. The email will include my account # and instructions for paying online. I will pay online for my services and products within 24 hours after receiving the email.

❑ **Option 3: Pay by Phone (Non-Automated)**

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)