

CONFIDENTIAL PATIENT CASE HISTORY

Last Name: _____ First Name: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Sex: M F Birthdate: _____ Age: _____ Marital Status: M S W D

Social Security #: _____

E-Mail: _____

Emergency Contact & Telephone: _____

How did you hear about Capital Sports Injury Center?

<input type="checkbox"/> Personal Referral – Name:	<input type="checkbox"/> Graston Techniques Website	<input type="checkbox"/> Running Club
<input type="checkbox"/> Doctor Referral – Name:	<input type="checkbox"/> Web Search	<input type="checkbox"/> Cycling Club
<input type="checkbox"/> Active Release Techniques Website	<input type="checkbox"/> Our Sign	<input type="checkbox"/> Other: _____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

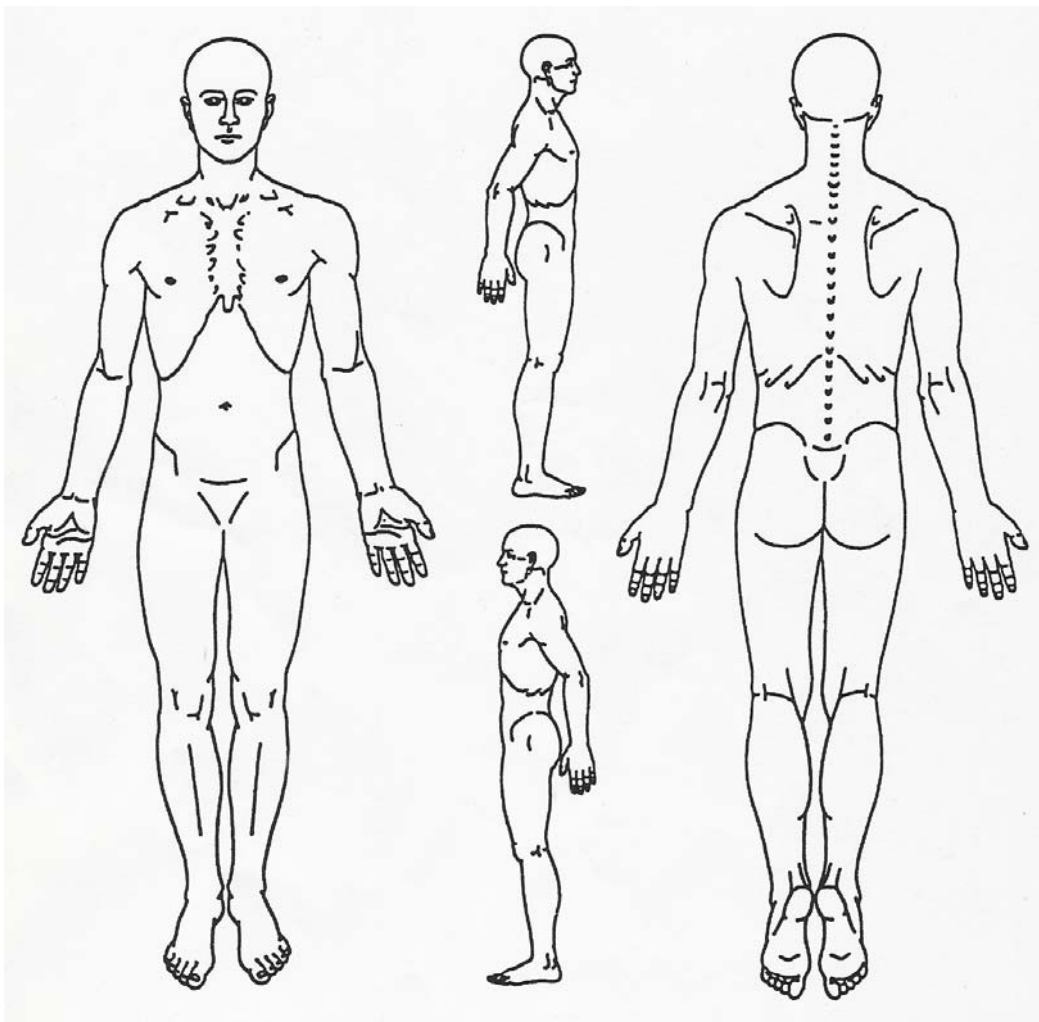
Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

PAIN DRAWING – ONE COMPLAINT PER DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. Please complete one drawing per area of pain, e.g. If you have shoulder, neck, and knee pain, complete three drawings.

A = Ache	B = Burning	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	T = Throb
DP= Deep	SH= Shallow	C = Cold	O = Other



Please circle how you would rate your pain RIGHT NOW: 0 means no pain, 10 means agony
 (No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

Please circle your TYPICAL or AVERAGE PAIN: 0 means no pain, 10 means agony
 (No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?
 (No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?
 (No Pain) **0 1 2 3 4 5 6 7 8 9 10** (worst possible pain)

NAME: (please print) _____

SIGNATURE: _____ DATE: _____

COMPLAINT

(One area per form, e.g. If you have shoulder, neck, and knee pain, please complete three forms)

What is your major/presenting complaint? (Please provide an exact description)

What is the location of the complaint? _____

When did the pain begin (be as specific as possible)? _____

Is the pain constant (all day long, no relief)? Yes No

Does the pain come and go? Yes No If yes, how frequent is it (e.g., times per day or times per week)?

Was there a precipitating event? Yes No If yes, what (e.g., lifting, bending, etc.)?

What makes the condition worse? Bending Lifting Twisting Sitting Standing Pushing Pulling Other

How does it interfere with or restrict your daily living (e.g., unable to lift child, unable to put on coat, etc.)?

What makes the condition better (e.g., ice, heat, rest)?

Do you have a history of similar conditions in the past? Yes No If yes, when? _____

Is the condition getting: Worse Same Better

Is there a particular time of day when your condition is worse? Morning Afternoon Evening Night Activity

Have you had other examination and/or treatment of this problem? Yes No

If yes, when? _____ By whom? _____

Have you had any associated symptoms like (circle):

Unexplained weight loss	Infection	Dizziness
Loss of bladder or bowel control	Fever or chills	ringing in the ears
Pain that awakens you in the middle of the night	Persistent swelling	Visual changes
Complete loss of feeling	Rash	Difficulty breathing
Complete loss of strength	Debilitating Headache	Shortness of breath
Loss of coordination	Nausea	Chest pain
Trouble balancing	Vomiting	Difficulty swallowing

Women only: Are you pregnant? Yes No

CAPITAL SPORTS INJURY CENTER, Steven M. Horwitz, D.C.

OFFICE POLICY

Hello and welcome to Capital Sports Injury Center. It is our goal to provide you with the best chiropractic and rehabilitative care available in the area. This includes a clear definition of our office policies stated below. Please take the time to read and sign where appropriate. If you have any questions please do not hesitate to ask. We look forward to working together to help you **regain and maintain your health!**

APPOINTMENT POLICY

Whether your appointment is with the doctor or the functional exercise specialist, your appointment time is reserved for only you. Our office DOES NOT double book appointments. **24 hours notice is required should you need to cancel an appointment.** You will be charged the full fee of your office visit should you fail to give 24 hours notice. It is important that you be on time for your appointment. If you are late, we will make every effort to see you, but it may not always be possible. You will still be responsible for your appointment fee if you are late.

Signature _____ Date _____

PAYMENT POLICY

1. Payment is due at the time services are rendered. We accept cash, Visa/MasterCard, or a personal check.
2. A \$30 reprocessing fee will be charged to your account should any personal check fail to clear.

Signature _____ Date _____

IMPORTANT INFORMATION – PLEASE READ

On your first visit, the doctor will take a history and perform a thorough examination. Please think about your condition and be able to answer the following questions:

- When did your pain begin? Was the onset sudden or gradual?
- Where is the specific site of your pain?
- If you have more than one area of pain, which is the most painful and most important one to treat?
- What activities or movements increase your pain?
- What, if anything, diminishes your pain?
- What movements or activities are you unable to perform due to your condition?

Please bring:

- Shorts and a sleeveless T-shirt
- Any prior X-rays, MRIs, CAT Scans (films and reports), blood work reports and any other important medical records

What can we do for you...?

We want your experience at our clinic to be a good one. What would you like to achieve by coming to our clinic?

FREQUENTLY ASKED QUESTIONS ABOUT CHIROPRACTIC CARE

What education does a chiropractor receive?

A four-year undergraduate degree is required to be accepted to chiropractic school. Chiropractic school is a four-year program consisting of 4800 hours of classroom, laboratory, and clinical study, including anatomy, physiology, chiropractic technique, radiology, biochemistry, toxicology, biomechanics, nutrition, diagnosis and physical examination, and a one-year internship. Upon completion, a Doctor of Chiropractic (D.C.) degree is granted.

Can a chiropractor really make a diagnosis?

YES! One case I will never forget illustrates the importance of proper diagnosis in chiropractic practice. A 45-year-old woman came in complaining of severe lower back pain. As I was examining her, I noticed that the end of each finger was deformed, like fluid had accumulated in the pad of each finger. The woman was a smoker and had been examined three months prior, but the changes to her fingers were never noticed by the other doctors. Lumbar (low back) X-rays showed destruction of a portion of two vertebrae and chest films showed a large metastasis (tumor) to the lung. She was immediately referred to an oncologist.

Do chiropractors treat muscles as well as bones?

YES! When muscles (tendons and ligaments also) are “pulled” or “strained” it means they have torn. Think of each muscle fiber as a single strand of rope. Did one strand of rope tear or did the entire rope tear? When this tear heals, it forms a tight knot called an adhesion (like the lumps when you knead bread dough). To break up this knot, we use several techniques: Active Release Technique® and Graston Technique®, Kinesio® Tape, Cold Laser, and Corrective Exercise. Medications like ibuprofen (Advil, Motrin, Nuprin), naproxen (Aleve), Celebrex or Vioxx can help temporarily with the initial inflammation and pain, but they prevent proper healing of the muscle tissue and have significant side effects, especially gastro-intestinal bleeding.

How long do I have to come for treatment?

No patient is treated longer than they want or need. Our motto is “We don’t keep you coming, we get you going!” Getting well and STAYING well is the goal. Most of our patients realize the benefits of what we call performance care.

NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Capital Sports Injury Center, Steven M. Horwitz, D.C., a Maryland Chiropractic Practice (the "Practice"), in accordance with applicable federal and state law, is committed to maintaining the privacy of your protected health information ("PHI"), in other words, information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI in the following ways:

- Treatment
- Payment
- Health Care Operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences.

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

- **Restrictions:** To request restricted access to all or part of your PHI. To do this, please make this request in writing. We are not required to grant your request.
- **Confidential communications:** To receive correspondence of confidential information by alternate means or location. To do this, please make a request in writing.
- **Access:** To inspect or receive copies of your PHI. To do this, please submit a request in writing.
- **Amendments:** To request changes be made to your PHI. To do this, please submit a request in writing.
- **Accounting:** To receive an accounting of the disclosures by us of your PHI in the six years prior to your request. . To do this, please submit a request in writing.
- **This notice:** To get updates or reissue of this notice, at your request.
- **Complaints:** To complain to our office or the U.S. Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

Our duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy contact: To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Steven M. Horwitz, D.C., at 12200 Tech Road, Suite 104, Silver Spring, MD 20904 or via email at painfree123@gmail.com.

Effective Date: This Notice is in effect as of April 14, 2003. A complete copy of the Notice of Privacy Practice is available at the reception desk.

Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Print Patient Name

Sign Patient Name

Date

