

# 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.

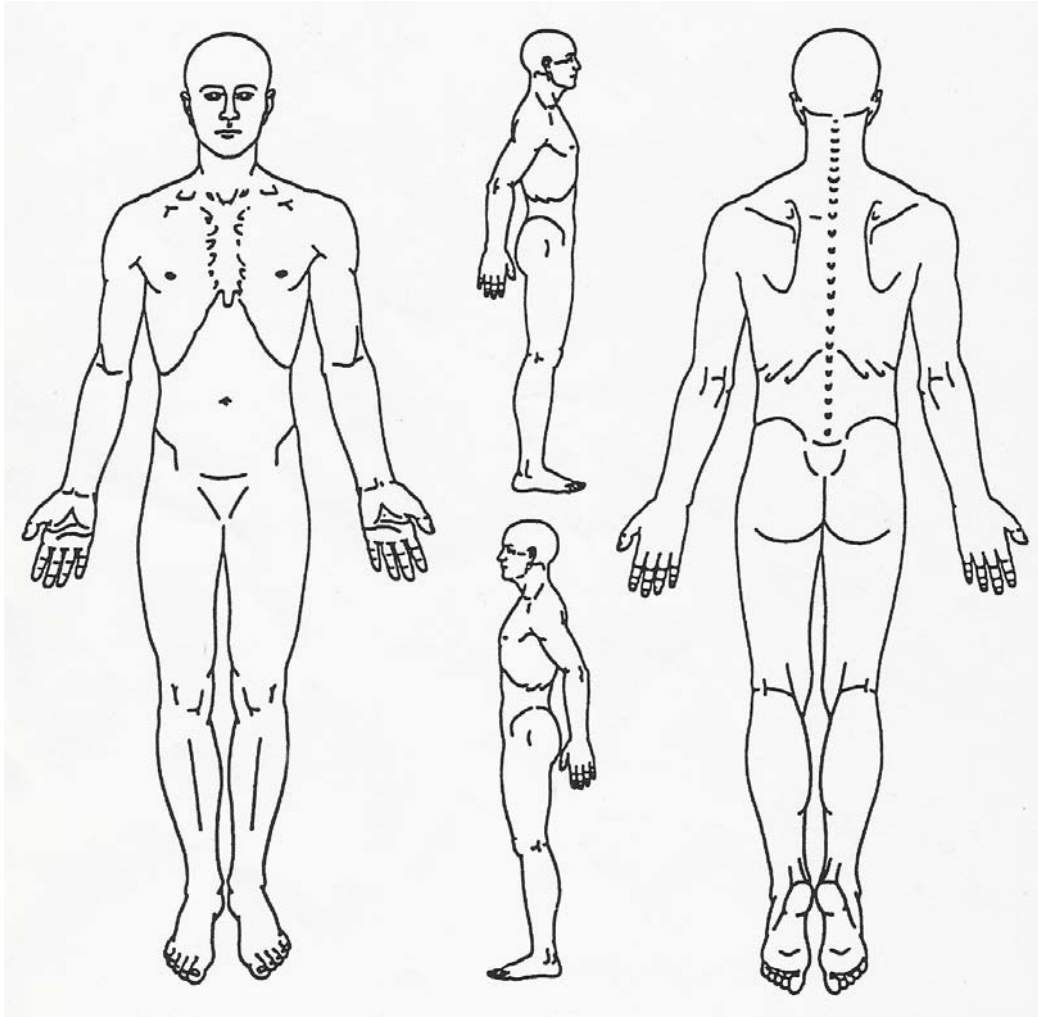
Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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)

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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.)?

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

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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

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.    301-622-9000    www.DCSportsInjury.com  
Silver Spring    Georgetown



# WORK INJURY HISTORY

Date of accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ (AM/PM)

Please describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you receive medical attention at the scene of the accident?  Yes  No

If yes what was done? \_\_\_\_\_

Were you taken by ambulance to the hospital?  Yes  No If yes, where? \_\_\_\_\_

What was done? \_\_\_\_\_

What was the diagnosis given? \_\_\_\_\_

Please list prescribed medications: \_\_\_\_\_

Where did you go immediately after the accident?  Hospital/Doctor  Resumed activities  Home  This office

Hospital or Doctors office: Where? \_\_\_\_\_ Were you examined?  Yes  No

Were you x-rayed?  Yes  No If yes, what area? \_\_\_\_\_ What treatment was given? \_\_\_\_\_

Please list medications: \_\_\_\_\_

Did you return to the doctor's office?  Yes  No If yes, please list dates: \_\_\_\_\_

Second Doctor/Clinic: \_\_\_\_\_ Date of first visit: \_\_\_\_\_

Were you examined?  Yes  No Were X-rays taken?  Yes  No

Were you given treatment?  Yes  No If yes, explain \_\_\_\_\_

Please list medications: \_\_\_\_\_

Did you return to the doctor's office?  Yes  No If yes, please list dates: \_\_\_\_\_

## CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Cold sweats   |
| <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Head heavy           | <input type="checkbox"/> Loss of memory     | <input type="checkbox"/> Feet cold     |
| <input type="checkbox"/> Neck stiffness      | <input type="checkbox"/> Pins/Needles in arms | <input type="checkbox"/> Ears ring          | <input type="checkbox"/> Hands cold    |
| <input type="checkbox"/> Sleeping problems   | <input type="checkbox"/> Pins/Needles in legs | <input type="checkbox"/> Face Flush         | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in ears      | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Mid back pain       | <input type="checkbox"/> Nervousness          | <input type="checkbox"/> Loss of balance    | <input type="checkbox"/> Diarrhea      |



# 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. Please take the time to read and sign at the bottom of the page. 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 and/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.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
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



**Steven M. Horwitz, D.C.**

## **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/ X-RAYS**

To \_\_\_\_\_

Doctor or Hospital

\_\_\_\_\_  
Address

I hereby authorize and request you to release the medical records of:

\_\_\_\_\_  
Patient

**To:** Steven M. Horwitz, D.C.  
12200 Tech Road, Suite 104  
Silver Spring, MD 20904  
301-622-9000 301-6221961 (fax)

Date \_\_\_\_\_ Signed \_\_\_\_\_

Witness \_\_\_\_\_ Relationship \_\_\_\_\_

## 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](mailto: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**