Dr. Spiro Theodore
Potomac Valley Chiropractic
12105 Darnestown Road, Suite L – 8
Gaithersburg, MD 20878

Patient Intake Form

Full Name: _____ **Date:** _____ **Chart#:** _____

Date of Birth:_____ **Gender**: ___Male ___Female **Height** _____ **Weight** _____ **Right OR Left Handed:** ____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ Cell Phone: _____

*Work Phone (optional):*_____ **Email:** _____

Cell Phone Carrier (for text messages): ____Verizon ____AT&T ____Sprint ____T-Mobile *Other:* _____

Contact Preference: _____Home Phone _____Cell _____Work _____Email

Marital Status: _____Married _____Divorced _____Single _____Widowed _____Separated

Emergency Contact (Name/Number/Relation): _____

Occupation: _____ **Primary Language:** ____English _____Spanish *Other*: _____

Race: ____Native Hawaiian/Other Pacific Islander _____Asian _____Latino or Hispanic _____White

_____Black/African American _____*Decline to State* *Other:* _____

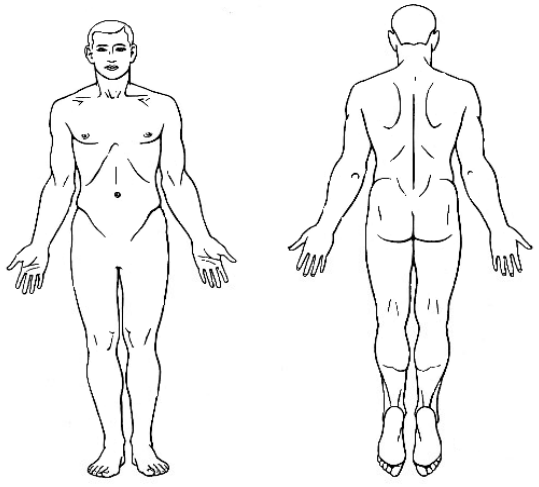
Primary Care Physician Name/Phone #: _____

1. Is today's problem caused by: Auto Accident or a Workman's Compensation? **Yes** or **No**

*Please mark the diagram below using the following:

N = Numbness ***S*** = Stiffness
T = Tingling ***B*** = Burning ***P*** = Pain

PROBLEM AREA #1 (MAIN PROBLEM)



What is your main Complaint today?

_____
_____

When did this problem start? How?

_____

3. How often do you experience your symptoms?

☐ Constantly (76-100% of the time)
☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time)
☐ Intermittently (0-25% of the time)

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4. How would you describe the type of pain?

- ☐ Sharp
- ☐ Dull
- ☐ Diffuse
- ☐ Achy
- ☐ Burning
- ☐ Shooting
- ☐ Stiff
- ☐ Numb
- ☐ Tingly
- ☐ Sharp with Motion
- ☐ Shooting with Motion
- ☐ Stabbing with Motion
- ☐ Electric like with Motion
- ☐ OTHER: _____

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (*10 being the worst*), what number would you rate your problem?

BEST: _____ WORST: _____ How do you feel today? _____

7. How much has the problem interfered with your work?

☐ Not at all ☐ Moderately ☐ Extremely
☐ A little bit ☐ Quite a bit

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ Moderately ☐ Extremely
☐ A little bit ☐ Quite a bit

9. Who else have you seen for your problem?

- ☐ Chiropractor
- ☐ ER Physician
- ☐ Massage Therapist
- ☐ Neurologist
- ☐ Orthopedist
- ☐ Physical Therapist
- ☐ Primary Care Physician
- ☐ OTHER: _____
- ☐ No One

10. How do you think your problem began?

_____

11. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

12 A. What makes your problem worse? (ex: Bending, Lifting, Sitting, etc …)

_____

12 B. What makes your problem Better? (ex: Bending, Lifting, Sitting, etc …)

_____

13. What concerns you the most about your problem; what does it prevent you from doing?

_____

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14. How would you rate your overall Health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

15. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

16. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ ALS

17. Please check (✓) any of the following that you have currently *OR* have experienced in the past

	PAST	PRESENT		PAST	PRESENT		PAST	PRESENT
Headaches/Migraines	____	____	Joint Pain/Stiffness	____	____	Weight Gain/Loss	____	____
Neck Pain	____	____	Arthritis	____	____	Night Sweats	____	____
Upper Back Pain	____	____	Rheumatoid Arthritis	____	____	Abdominal Pain	____	____
Mid Back Pain	____	____	Cancer	____	____	Hepatitis	____	____
Low Back Pain	____	____	Asthma	____	____	Liver Disorder	____	____
Shoulder Pain	____	____	High Blood Pressure	____	____	Gall Bladder Disorder	____	____
Elbow/Upper Arm Pain	____	____	Heart Attack	____	____	Diabetes	____	____
Kidney Disorders	____	____	Chest Pains	____	____	C-Sections	____	____
Wrist Pain	____	____	Stroke	____	____	Difficult Birth	____	____
Hand Pain	____	____	Kidney Stones	____	____	Frequent Urination	____	____
Hip Pain	____	____	Seizures	____	____	Smoking/Tobacco	____	____
Upper Leg Pain	____	____	Depression	____	____	Drug/Alcohol	____	____
Knee Pain	____	____	Bowel Problems	____	____	HIV/AIDS	____	____
Ankle/Foot Pain	____	____	Loss of Bladder Control	____	____			
Jaw Pain	____	____	Prostate Problems	____	____	OTHER: _____		

18. List all prescription medications you are currently taking:

_____

19. List all of the over-the-counter medications or nutritional supplements you are currently taking:

_____

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20. Do you have any allergies? _____Yes _____ No

If YES, list them: _____

21. List all surgical procedures you have had:

_____

22. What activities do you do at work?

SIT:	☐ Most of the day	☐ Half of the day	☐ A little of the day
STAND:	☐ Most of the day	☐ Half of the day	☐ A little of the day
COMPUTER WORK:	☐ Most of the day	☐ Half of the day	☐ A little of the day
ON THE PHONE:	☐ Most of the day	☐ Half of the day	☐ A little of the day

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? _____ Yes _____ No

If yes, why? _____

25. Have you had significant past trauma? (Falls, accidents, car accidents) _____ Yes _____ No

If yes, date them and give a brief description.

_____

26. Anything else pertinent to your visit today?

_____

Potomac Valley Chiropractic never discloses your information to anyone selling or promoting products or services. HIPPA is strictly enforced. Please complete the following consents:

OK to text appointment reminders, cancellations to your cell phone? ____Yes ___No
Ok to leave voice messages on home and/or cell? ___Yes ___No ___Cell only ___Home only
Ok to send email to the address you provided? ____Yes ___No

*Is there anyone you consent to sharing information with about your appointments, treatment, insurance or financial issues (other than insurance companies or attorneys):*_____

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Insurance Information

Name of Insurance Company: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. All Copay's and fees are required at the time of service.

Patient's Signature_____Date:_____
(Or Guardian if Minor)

Doctor's Signature _____Date:_____

Patient's Initials: _____