Date_____
1st visit_____
2nd visit_____

CHIROPRACTIC CENTER OF ANNAPOLIS

108 Old Solomons Island Rd., Bldg. 2 Annapolis, MD 21401
(410) 266-5054 Fax (410) 266-6205
Dr. William J. Boro | Dr. Mary X. Psaromatis

Patient Intake Form

Patient Name:_____ SSN: _____
DOB: _____
(If minor, guardian's name) _____ Guardian SSN:_____
Address: _____ Home Phone:_____
City, State, Zip: _____ Work Phone: _____
Nature of Complaint: _____ Have you seen a Chiropractor before? _____
Date Started:_____ Referred by:_____
Email Address:_____ Has your case been settled? □Yes □No

Is condition due to: □Auto Accident □Job Related Injury □Other

Treatment will be paid by? □Cash, Check, Charge □Workers Comp □Auto Insurance □Major Medical □Medicare □Other
Insurance Company: _____

Dear Patient:
Thank you for coming to us for treatment. Your consultation and exam will help us determine if chiropractic care can help you.
If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank you!

Race: □White □Black □Latino □Asian □Other _____Preferred Language: _____
Primary Care Doctor:_____ Address _____
Do you give us permission to contact your doctor with information appropriate to your case? □Yes □No

Age:_____ Height:_____ Weight:_____ Marital Status: □Single □Married □Widowed □Divorced
Occupation: _____ Name of Spouse: _____
Employer:_____ Spouse's Employer:_____
Employer's Address: _____ Address _____
_____ _____
Ages of Children:_____ Spouse's Work Phone: _____
Name and phone number of nearest relative not living with you:
Name:_____ Relationship: _____ Phone: _____
Name:_____ Relationship: _____ Phone: _____

Insurance Policy: It is our office policy to bill your insurance company for patient services as a courtesy to you, (and assist in the proper handling of insurance claims, providing: 1) We have all the necessary information about your policy; 2) You inform us of any changes in coverage when they occur; 3) You understand that the Chiropractic Center of Annapolis makes no guarantee that your insurance company will cover all bills for services rendered; 4) You understand that you are ultimately responsible for payment of all services rendered; 5) You pay the first visits and the deductible as it accrues. This will avert the development of a large bill down the line in the event your insurance company doesn't cover all expenses. I have read and understood and agree to the above policy.

Signature _____ Date _____

CHIROPRACTIC CENTER OF ANNAPOLIS

108 Old Solomons Island Rd., Bldg. 2
Annapolis, MD 21401 (410) 266-5054

Dr. William J. Boro | Dr. Mary X. Psaromatis

New Patient History Form

Patient Name:_____ Date: _____

Please list your complaints in order of severity *How and when did your problem begin?*

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____

Please list below any treatment or diagnosis you have received for these conditions:

Who, When or Where seen *Type of Treatment or Diagnosis*

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____

Have you had this or similar conditions in the past? □Yes □No
Is this condition getting progressively worse? □Yes □No
Is this condition interfering with your:
□Work □Sleep □Daily Routine
How would you classify your condition?
□Minor □Fairly severe and getting worse
□Involved □Serious, want cause and correction
If you have ever received treatment or have been hospitalized for a health condition in the last 10 years, list below:

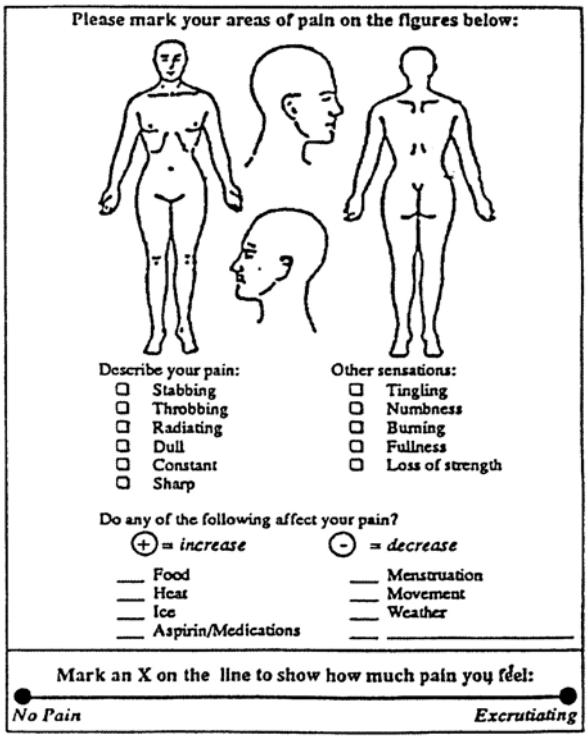
Date	Reason

Have you ever been in an auto accident? □Never
□Past year □Past 5 years □Over 5 years
Describe: _____
When did you last have:

Spinal X-ray:	□Never	□0-6 months	□6-18 months	□Longer
Spinal Exam:	□Never	□0-6 months	□6-18 months	□Longer
Physical Exam	□Never	□0-6 months	□6-18 months	□Longer
Dental Exam:	□Never	□0-6 months	□6-18 months	□Longer

Are you interested in recommendations regarding:
□diet □nutritional support □exercise instruction
□blood work/hair analysis/other lab work □allergy evaluation
□orthotics for your shoes

What type of service do you desire?
□Temporary Relief
□General Stabilization (medium care)
□Specific Correction or stabilization if possible(optimum health care)



Please complete other side

List any drugs you now take:

_____
_____
_____
_____
_____

Drug Allergies _____

Indicate with a check if you wear:

□Heel Lifts □Inner Soles
□Arch Supports □High Heels

Age of your mattress_____
□Comfortable □Uncomfortable

Indicate ability to perform the following activities:

Painful	Difficult	Unable	
□	□	□	Coughing or sneezing
□	□	□	Getting in & out of car
□	□	□	Turning over in bed
□	□	□	Walking short distances
□	□	□	Standing more than 1 hour
□	□	□	Sitting at a table
□	□	□	Bending over forward
□	□	□	Straightening up
□	□	□	Kneeling
□	□	□	Dressing self
□	□	□	Sleeping
□	□	□	Stooping
□	□	□	Gripping
□	□	□	Pushing
□	□	□	Reaching
□	□	□	Sexual activity

Have you ever suffered from:

	Now	Past	Ongoing
Back pain	□	□	□
Neck pain	□	□	□
Ulcer	□	□	□
Reproductive problems	□	□	□
Arthritis	□	□	□
Headaches	□	□	□
Heart problems	□	□	□
Diabetes	□	□	□
Frequent colds	□	□	□
Constipation/diarrhea	□	□	□
Asthma	□	□	□
Hemorrhoids	□	□	□
Urinary tract infections	□	□	□
Impotency	□	□	□
Ear infections	□	□	□
Gall bladder	□	□	□

DAILY HABITS	None	Light	Medium	Heavy
Alcohol	□	□ 1-2 oz	□ 3-5 oz	□ >5 oz
Appetite	□	□	□	□
Artificial Sweetener	□	□	□	□
Caffeine/Sodas	□	□ 1-2 cups	□ 3-6 cups	□ 7 cups
Exercise	□	□	□	□
Minerals, herbs or Vitamins	□	□	□	□
Salty Foods	□	□	□	□
Sugary Products	□	□	□	□
Tobacco	□	□ 1/2 pack	□ 1/2-1 pack	□ >1pack
Water	□	□ 1-10 oz	□ 10-30 oz	□ >30 oz

If any of these diseases run in your family, please circle who was affected:

Diabetes	Grandfather	Grandmother	Father	Mother
Heart Disease	Grandfather	Grandmother	Father	Mother
High Blood Pressure	Grandfather	Grandmother	Father	Mother
Arthritis	Grandfather	Grandmother	Father	Mother
Cancer	Grandfather	Grandmother	Father	Mother
	Grandfather	Grandmother	Father	Mother
	Grandfather	Grandmother	Father	Mother

Are you or do you think you may be pregnant? □yes □no
Have you missed days of work due to your problem? □yes □no
Does pain wake you at night? □yes □no
Is the pain worse in the AM or PM? □AM □PM
□no difference

Indicate how many hours of your day are spent:
Standing _____ Sitting _____
Walking _____ Sleeping_____

The nature of the procedure, possible alternative methods of treatment, the risks involved, and possible complications have been fully explained to me by my chiropractor. No guarantee or assurance has been given by anyone as to the results that may be obtained.

Patient Signature _____

□Accepted for care
□Referred to
_____
□Request records from:
□AAGH □Dr. O'Brien
□Other_____
□Further tests required:
□Blood □Urine □X-Ray
□Other _____