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

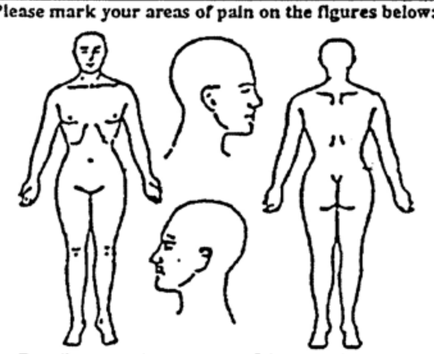
Have you ever been in an auto accident? □Never
□Past year □Past 5 years □Over 5 years
Describe: ____
When did you last have:

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 mark your areas of pain on the figures below:



Describe your pain:
- ❑ Stabbing
- ❑ Throbbing
- ❑ Radiating
- ❑ Dull
- ❑ Constant
- ❑ Sharp

Other sensations:
- ❑ Tingling
- ❑ Numbness
- ❑ Burning
- ❑ Fullness
- ❑ Loss of strength

Do any of the following affect your pain?
⊕ = *increase* ⊖ = *decrease*

___ Food
___ Heat
___ Ice
___ Aspirin/Medications
___ Menstruation
___ Movement
___ Weather
___ ____________

Mark an X on the line to show how much pain you feel:

No Pain ———————————————— *Excrutiating*

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 ______________________

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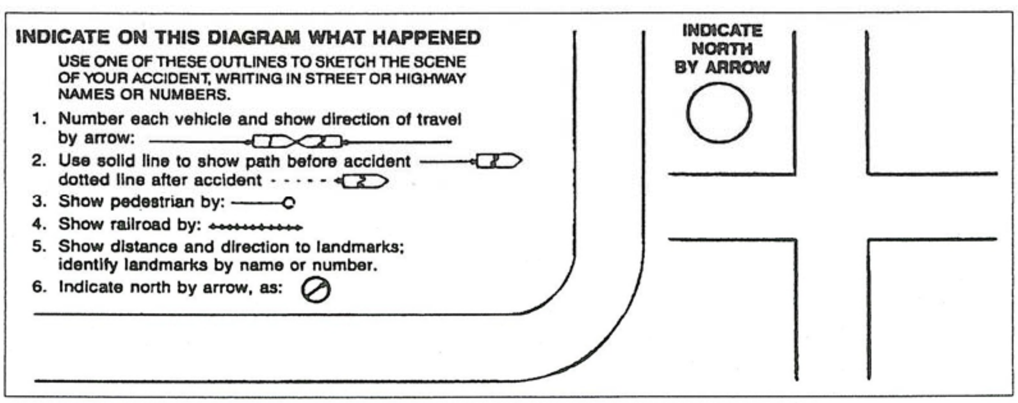
PERSONAL INJURY HISTORY

Name:____Date:_________________________
File Number:____________________________________
History of Occurrence:
Date of Accident:__________________ Time: ____________________(AM/PM)
Were you: □ The Driver □ Passenger □ Front Seat □ Back Seat □ Pedestrian
Number of people in vehicle: ________ Type of Vehicle: ___________________________
What was approximate damage to your vehicle? ___________________________________
Visibility at time of accident: □ Poor □ Fair □ Good □ Rainy
Conditions at time of accident: □ Road wet □ Road icy □ Snowy □ Clear □ Dark □ Other
Your car: □ Hit another car □ Was hit in the □ right □ left □ rear □ front □ side
What direction were you headed? □ North □ East □ South □ West
Name of street:____
What direction was the other vehicle headed? □ North □ East □ South □ West
Name of street:____

Indicate on this diagram how the accident happened:



Describe in detail how the accident happened:
____
____
____
Were you wearing □ seat belts? □ shoulder harness?
If you wear glasses, where were they after the accident? ____
Head/body position at the time of impact:
□ head □ turned right □ turned left □ looking back
□ body □ rotated right □ rotated left □ straight in sitting position
At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: __________
____

As a result of the accident were you:
□ OK □ Rendered unconscious □ Dazed, circumstances vague □ Shaken but could function
Were you able to get out of the car and walk unaided? □ Yes □ No
Could you move all parts of your body? □ Yes □ No If no, what parts and why?____________________
____
Did you get bleeding cuts or bruises? □ Yes □ No
If yes, describe cuts or bruises: ____
Since this injury occurred, are your symptoms: □ Improving □ Getting worse □ The same

Check symptoms you have notices since accident

□ Headache	□ Irritability	□ Numbness in toes	□ Muscle Jerking	□ Nausea	□ Neck pain
□ Chest pain	□ Feet cold	□ Shortness of breath	□ Face Flushed	□ Neck stiff	□ Pins & needles in arms
□ Fatigue	□ Tension	□ Loss of balance	□ Stomach upset	□ Fainting	□ Pins & needles in legs
□ Dizziness	□ Depression	□ Sleeping problems	□ Low back pain	□ Fever	□ Eyes sensitive to light
□ Ears ring	□ Diarrhea	□ Mid back pain	□ Head seems to heavy	□ Constipation	□ Loss of memory
□ Nervousness	□ Cold sweats	□ Numbness in fingers	□ Loss of smell	□ Loss of taste	

□ Symptoms other than above____

Symptoms are better in: □ AM □ Midday □ PM
Symptoms are worse in: □ AM □ Midday □ PM
□ Symptoms do not change with the time of day
Prior to the accident, have you ever had symptoms similar to what you're experiencing now? □ Yes □ No
Did you go seek medical help immediately/soon after the accident? □ Yes □ No
If yes, how did you get there? □ Drove own car □ Someone else drove me □ Ambulance □ Police
Doctor/Hospital/Clinic seen: ____
Were you examined? □ Yes □ No Were X-Rays taken? □ Yes □ No Were you given treatment? □ Yes □ No
If yes, what was the treatment given you?____
What benefits did you receive from the treatment?__________________________________
Date of last treatment?____

Any other treatment received:
Name ______________________________ Type of treatment ______________________________
Address ____________________________ Date__________ Telephone ______________________
Name ______________________________ Type of treatment ______________________________
Address ____________________________ Date__________ Telephone ______________________
Name ______________________________ Type of treatment ______________________________
Address ____________________________ Date__________ Telephone ______________________

(Please list additional treatments on a separate sheet of paper)

Do you have any previous illnesses which relate to this case? □ yes □ no If yes, please describe:____________
____
Did you have any physical complaints just before the accident? □ yes □ no If yes, please describe: __________
____
Have you ever been involved in an accident before? □ yes □ no If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received: ______________________________________
____
Do you notice any activities of your daily routines that are different now than from before the accident? □ yes □ no
If yes, please describe:____

If you have ever received treatment or have been hospitalized for a health condition in the last 10 years, list below:

Date	Reason

List any drugs you now take:

____

____

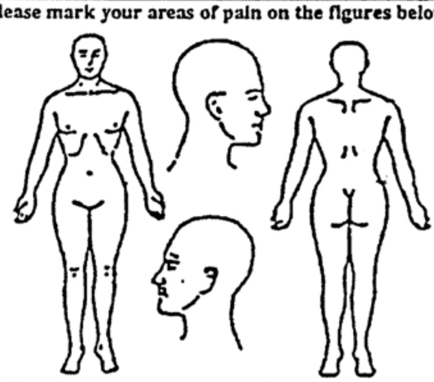
____

____

____

Drug Allergies ___________________________

Please mark your areas of pain on the figures below:



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___ Food
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___ Ice
___ Aspirin/Medications
___ Menstruation
___ Movement
___ Weather
___ ____________

Mark an X on the line to show how much pain you feel:

No Pain ———————————— *Excrutiating*

Indicate ability to perform the following activities:

	Painful	Difficult	Unable
Coughing or sneezing	☐	☐	☐
Getting in & out of car	☐	☐	☐
Bending forward to brush teeth	☐	☐	☐
Turning over in bed	☐	☐	☐
Walking short distance	☐	☐	☐
Standing more than 1 hour	☐	☐	☐
Sitting at a table	☐	☐	☐
Lying on back	☐	☐	☐
Lying flat on stomach	☐	☐	☐
Bending over forward	☐	☐	☐
Climbing	☐	☐	☐
Kneeling	☐	☐	☐
Balancing	☐	☐	☐
Dressing self	☐	☐	☐
Sleeping	☐	☐	☐
Stooping	☐	☐	☐
Gripping	☐	☐	☐
Pushing	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐
Sexual activity	☐	☐	☐
Sport Activities	☐	☐	☐

Describe:______________________________________

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

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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

Indicate how many hours of your day are spent:
Standing _______________Sitting ________________
Walking ________________Sleeping ______________

Have you lost time from work as a result of this accident? □ yes □ no Have you returned to work? □ yes □ no

A) Did you return to your full responsibilities or have your duties or hours been reduced? Please explain:

____

____

B) Dates you were out of work: from_____________ to _____________.

Type of employment:

Do you have an attorney on this case? □ yes □ no If yes, fill in below:

Name:____
Address:____
Phone:____

Patient signature: ____ Date:____________________________________