Phone: (301) 217-0515

**1201 SEVEN LOCKS ROAD, SUITE 212**
**ROCKVILLE, MD 20854**
**Phone: 301-217-0515- Fax: 301-217-0585**
**www.prochiromed.com**

*Thank you for scheduling an appointment with Proactive Chiropractic and Physical Therapy. It is my pleasure to welcome you in advance of your first visit at our office. The following is some information to familiarize you with our practice. Please read and complete this packet carefully.*

| **Providers** | **Assistants** | **Massage Therapist** |
| --- | --- | --- |
| Joseph A. Pollack, D.C. | Kimberly Rea, P.T.A. | Carole Dean, L.M.T. |
| Ryan J. Mullen, D.C. | Yoshiko Spratley, C.A. | |
| Marshall A. Dispenza, D.C. | | |
| Yi Ju Chen, D.P.T. | | |

## *Office Hours*:*

Monday through Thursday: 7:00am- 7:00pm
Friday: 7:00am- 5:00pm

**Each provider has their own schedule during these hours depending on the day of the week. Please call for specific hours.*

## *To Prepare For Your Initial Visit:*

*Please bring your intake forms, license/photo ID, referral (if required) and health insurance card(s). If you are a personal injury claim, please bring ALL of your claim information. If you are unable to complete these forms ahead of time, please plan to arrive at least 30 minutes early so as not to cut into your appointment time filling out forms. Most patients prefer to wear comfortable clothing and shoes to their appointment.

***IMPORTANT: Our suite (212) is located in the back of the building. There is no access if you enter through the main lobby, so please drive around to the back of the building and park near the large black ramp. We are up the stairs and to the left. If you need more specific directions, please utilize our website.***

If you have any further questions, I will be happy to answer them for you prior to your appointment. Once again, we greatly appreciate you selecting Proactive for your chiropractic, physical therapy, and massage therapy care. We look very forward to meeting you!

Sincerely,
Kristen Martin
*Office Manager*

**Proactive Chiropractic and Physical Therapy**
1201 Seven Locks Road Ste. 212, Rockville, MD 20854
Phone: (301) 217-0515 Fax: (301) 217-0585
www.ProChiroMed.com

Date: ____/____/______ Patient's Full Name: ______________________________

Home Phone: ________________ Cell Phone: ________________ E-Mail: ________________

☐Male ☐Female Age: _____ Date of Birth: ____/____/______ Social Security #: ______-______-______

Address: ______________________________ City: __________ State: ______ Zip: ______

How would you like to be addressed by our staff? ______________________________

☐Married ☐Single ☐Widowed ☐Separated ☐Divorced Number of Children: ______ Ages: __________

Occupation: ________________ Employer: ________________ Business Phone: ________________

Emergency Contact: ______________________________ Relationship: ________________

Phone: ________________ City: ________________ State: ____________ Zip: ____________

Family Physician: ______________________________ Address: ______________________________

City: ________________ State: __________ Zip: __________ Phone: ________________

May our office inform your physician of our exam findings, diagnosis, and treatment plan? ☐Yes ☐No

Whom may we thank for referring you? ______________________________

## CHIEF COMPLAINT

(No, you can't just say your "husband" or "wife")

Chief complaint: ______________________________

Secondary or related complaint(s) if any: ______________________________

Was the Onset: ☐Gradual ☐Sudden

Since the onset, has it gotten: ☐Worse ☐Stayed same ☐Better

When did this bout begin? ________

Has this occurred before: ☐Yes ☐No

How long ago since first occurrence? _____ (please circle) months / years ago

What caused the pain: ☐no apparent cause ☐one incident ______________________________

How intense is the pain: ☐Minimal ☐Mild ☐Moderate ☐Severe/Excruciating

Have you had any changes in bowel or bladder functioning? ☐Yes ☐No

Have you been treated for your present problem in the past? ☐Yes ☐No

If yes, when: __________ If yes, by whom: ______________________________

Outcome: ☐No effect ☐Somewhat better ☐Resolved

What does your condition prevent you from normally doing? ☐sitting/driving ☐walking ☐running ☐golfing ☐swimming ☐weight lifting ☐work ☐playing with children ☐sleeping ☐normal activities of daily living ☐other: ______________________________

What is your long-term goal from treatment (e.g. play a round of golf without pain)? ______________________________

______________________________

Do you want this pain gone? ☐Just now ☐Forever

Is there anything else I should know? ______________________________

Proactive Chiropractic and Physical Therapy
1201 Seven Locks Road Ste. 212, Rockville, MD 20854
Phone: (301) 217-0515 Fax: (301) 217-0585
www.ProChiroMed.com

**Describe the quality of the complaint/pain:**
- ☐ sharp/ stabbing
- ☐ dull/ache
- ☐ pulling/tight
- ☐ tingling/numbness
- ☐ burning/throbbing
- ☐ other: ____________________

**Describe the location of the symptoms:**
- ☐ generalized dull, deep ache
- ☐ pin point
- ☐ pain starts localized, but then radiates
  Describe: ____________________
- ☐ other: ____________________

**The symptoms are:**
- ☐ more prevalent in the morning
- ☐ more prevalent at night
- ☐ better as the day goes on
- ☐ worse as the day goes on

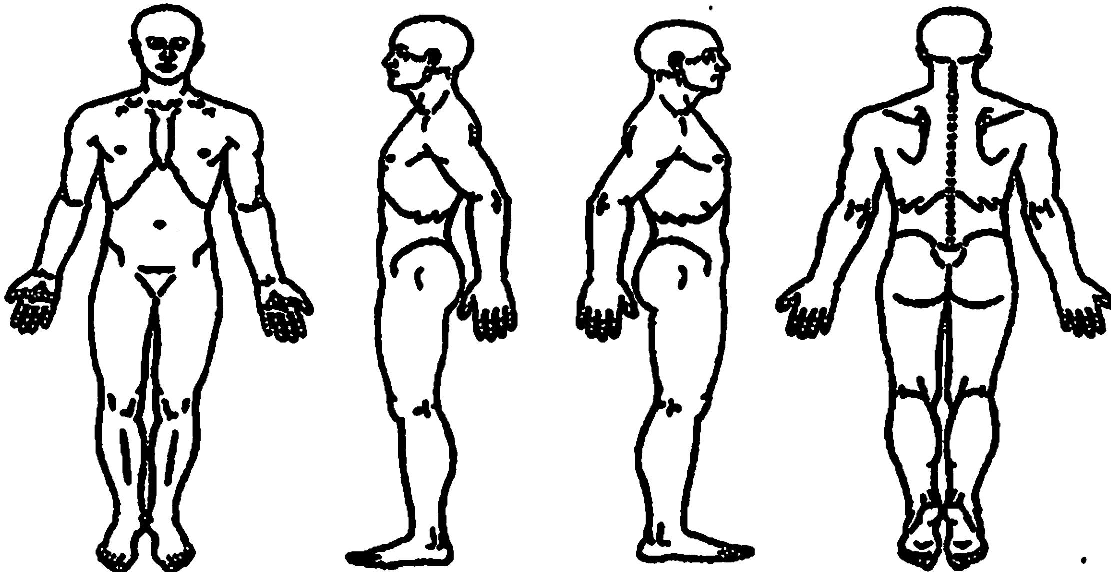
**How often daily are you aware of the symptoms:**
- ☐ intermittent (less than 25% of time)
- ☐ occasional (25-50% of time)
- ☐ frequent (50-75% of time)
- ☐ constant (75-100% of time)

**Does any of the following make the pain worse:**
- ☐ lifting/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ bending forward/leaning back
- ☐ other: ____________________

**Does any of the following make the pain better:**
- ☐ rest/laying down
- ☐ ice
- ☐ sitting
- ☐ heat
- ☐ walking/exercise
- ☐ aspirin
- ☐ standing
- ☐ other: ____________________

**The symptoms feel:**
- ☐ better with exercise/activity
- ☐ worse with exercise/activity
- ☐ no change with exercise/activity

**Does it interfere with your daily activities:**
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)



**Pain Scale**

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate — Severe

**Use the following letters to indicate the type and location of discomfort:**

A - Aching
B - Burning
N - Numbness/Tingling
P - Pins and Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

0

Proactive Chiropractic and Physical Therapy
1201 Seven Locks Road Ste. 212, Rockville, MD 20854
Phone: (301) 217-0515 Fax: (301) 217-0585
www.ProChiroMed.com

## STRESSORS

What medications are you currently taking? ___________________________

What vitamins/supplements are you currently taking? ___________________________

How many night per week do you drink alcohol? _____ On those nights, how many drinks do you have? _______

Do you smoke cigarettes? ☐Yes ☐No

How much mental stress do you experience? ☐Mild ☐Moderate ☐Severe

Do you eat vegetables with every meal? ☐Always ☐Sometimes ☐Never

What general physical activity do you do? ☐ No regular exercise ☐ Light exercise ☐ Strenuous exercise

What type of physical activity do you do? ☐ Cardiovascular Resistance Walking ☐ Other _______

Females only: Are you currently pregnant? ☐Yes ☐No

In general, would you say your health is (check one): ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

## PAST HEALTH HISTORY

Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem: ___________________________

What treatment(s) were received: ___________________________ Were they helpful? ☐Yes ☐No

Doctor's Name: ___________________________ Address: ___________________________

City: _______________ State: _____________ Zip: _____________ Phone: _____________

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries.

| Date | Injury/Fracture/Illness/Surgeries/Falls | Treatment | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please indicate any of the following illnesses you have had or currently have with approximate dates.

High Blood Pressure_____________ Prostate disease_____________ Multiple Sclerosis_____________

Heart disease_____________ Ulcer_____________ Headaches_____________

Stroke_____________ Allergies_____________ Cancer_____________

Diabetes_____________ Scoliosis_____________ Seizures_____________

Kidney disease_____________ Mental/Emotional_____________ Auto accident_____________

Fevers_____________ Upset stomach_____________ Other_____________

***Signature of Patient:*** ___________________________ ***Date:*** _____________

# MASSAGE THERAPY CONSENT FORM

I understand that the massage given to me by Carole Dean, LMT is for the basic purpose of relaxation and relief of muscle tension.

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy. I agree that nothing stated during the massage by the therapist will be construed as such.

I understand that if I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes can be adjusted to my level of comfort.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

PRINTED PATIENT (AND/OR GUARDIAN) NAME:_________________________________

SIGNATURE:________________________________________DATE:________________

**Financial and Cancellation Information for Massage Patients**

*Please initial*

I understand that Proactive Chiropractic and PT does not submit to health insurance for massages, and payment is due in full at the time of service.________

I understand that I may purchase a package in order to reduce the massage cost per visit. I agree that if I purchase a package, I must pay in full at the time of my first massage appointment.__________

I agree to be charged 50% of the cost of my massage if I cancel within 24 hours of my scheduled appointment time, or if I do not show up at all.________*

**Proactive understands that emergencies happen and conflicts come up. Please do your best to give us adequate notice (24 hours or more) when you need to cancel, as Carole's services are in very high demand. We will of course be reasonable with the cancellation fee if it is a true emergency that keeps you from attending your appointment, and/or calling.*