

# CONFIDENTIAL PATIENT CASE HISTORY

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: M S W D Sex M F

Occupation \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone: \_\_\_\_\_

Nearest Relative & Telephone \_\_\_\_\_

E-Mail \_\_\_\_\_ Referred by \_\_\_\_\_

## HEALTH INFORMATION

Have you had previous chiropractic care? Yes \_\_\_\_\_ No \_\_\_\_\_

What is your major complaint? \_\_\_\_\_  
\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_  
\_\_\_\_\_

Is this condition getting progressively worse? Yes \_\_ No \_\_ Constant \_\_ Comes and goes \_\_

Is this condition interfering with: Work \_\_ Sleep \_\_ Daily Routine \_\_ Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Other doctors who treated this condition \_\_\_\_\_

**PAIN LEVEL:** On a scale of 0-10, with 0 being pain free and 10 being you are in agony, where would you rate yourself?

\_\_\_\_\_

0    1    2    3    4    5    6    7    8    9    10

List surgical operations and year of occurrence: \_\_\_\_\_  
\_\_\_\_\_

Please list all drugs/medications you are now taking:

Do you have any allergies, if so please list and include allergies to any medications:

Are you wearing: \_\_\_\_\_ Orthotics    Heel Lifts \_\_\_\_\_    Arch supports \_\_\_\_\_  
How old is your bed? \_\_\_\_\_ With how many pillows do you sleep? \_\_\_\_\_  
Have you been in an auto accident?    \_\_\_ Past year    \_\_\_ Past 5 years    \_\_\_ Over 5 years    \_\_\_ Never    \_\_\_

Describe: \_\_\_\_\_

Have you had any other personal injury or accident? \_\_\_\_\_ If yes, when \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_

Do you **smoke?** \_\_\_\_\_ packs per day \_\_\_\_\_ for how long \_\_\_\_\_

**drink alcohol?** \_\_\_\_\_ drinks per week \_\_\_\_\_

**use caffeine?** \_\_\_\_\_ cups per day \_\_\_\_\_

**exercise regularly?** \_\_\_\_\_ what exercises \_\_\_\_\_

During the day (at work or at home) do you sit \_\_\_\_\_ computer \_\_\_\_\_ desk; stand in one position \_\_\_\_\_

lift \_\_\_\_\_ > 25lbs. \_\_\_\_\_ < 25lbs. Explain \_\_\_\_\_

**Have you ever suffered from?**

Dizziness \_\_\_\_\_    Backaches \_\_\_\_\_    Heart trouble \_\_\_\_\_    Diabetes \_\_\_\_\_

Arthritis \_\_\_\_\_    Headaches \_\_\_\_\_    Asthma \_\_\_\_\_    Digestive Disorders \_\_\_\_\_

Nervousness \_\_\_\_\_    Sinus Trouble \_\_\_\_\_    Neck Pain \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Has any family member (parents, brothers, sisters, grandparents) had any of the following disorders:    **Please list family member next to disorder**

High blood pressure \_\_\_\_\_    Heart Disease \_\_\_\_\_

Cancer \_\_\_\_\_    Diabetes \_\_\_\_\_

Thyroid \_\_\_\_\_    Kidney \_\_\_\_\_

Arthritis \_\_\_\_\_    Tuberculosis \_\_\_\_\_

Stroke \_\_\_\_\_    Lung disease \_\_\_\_\_

**INFORMED CONSENT:**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Dr. Horwitz. I understand 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 and sprains. I do not expect Dr. Horwitz to be able to anticipate or explain all risks and complications, and I wish to rely on Dr. Horwitz's judgment during the course of the procedure which Dr. Horwitz feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me and understand the above consent. By signing below I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition. I understand that payment is due at the time care is rendered and that no insurance is accepted.

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

Guardian or Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Maryland Sports Injury Center**  
Steven M. Horwitz, DC, CCSP, CSCS, USAW

**OFFICE POLICY**

Hello and welcome to Maryland Sports Injury Center. It is our goal to provide you with the best chiropractic and rehabilitative care available in the area. This includes a clear definition of our office policies stated below. Please take the time to read and sign where appropriate. 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**

**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.

Signature\_\_\_\_\_

Date\_\_\_\_\_

**PAYMENT POLICY**

1. Payment is due at the time services are rendered. As a courtesy to you, our office will gladly accept cash, Visa or MasterCard, or a personal check.
2. A \$25 reprocessing fee will be charged to your account should any personal check fail to clear.

Signature\_\_\_\_\_

Date\_\_\_\_\_

**PLEASE BRING THE FOLLOWING TO YOUR FIRST VISIT:**

1. Shorts and a sleeveless shirt (Tank top)
2. Any prior X-rays, MRI's, CAT Scans, blood tests and the accompanying reports.
3. Any other pertinent medical records related to your condition.

## 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.**

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 [drsteve@youcanbenefit.com](mailto:drsteve@youcanbenefit.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**