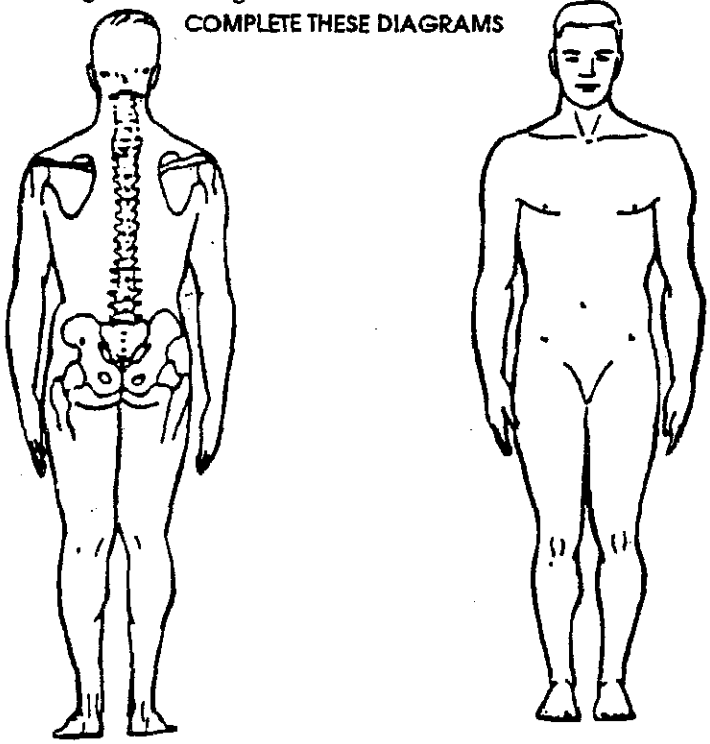
If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, constant, off & on, when standing, when sitting, etc., etc.

COMPLETE THESE DIAGRAMS



MAJOR COMPLAINT
(Please describe only your major problem)

How did this condition develop? (What casued it? How did it start?)

When was the very first time you were aware of this problem?

Have you ever had this problem or similar problem before? If yes, please explain:

Have you ever received any treatment for this condition? If yes, where and when, and what were your results?

Has this problem been getting better, worse, or staying the same?

Is there anything you do that makes your condition worse?

How has this condition affected your life?

A. Home life
B. Occupational life
C. Recreational life
D. Rest and Sleep life

Have you ever been in an automobile accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ Never

ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM

What surgery has been done?

Are you pregnant? ☐ Yes ☐ No

DRUGS YOU NOW TAKE: ☐ Nerve Pills ☐ Pain Killers ☐ Muscle Relaxers ☐ "Pep" Pills ☐ Tranquilizers ☐ Insulin ☐ Birth Control Pills ☐ Other (please list)

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name:

Dates consulted: For what problem?

Fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature Social Security No. Date

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty: 1 = "I can do it without any difficulty" 2 = "I can do it without much difficulty, despite some pain", 3 = "I manage to do it by myself, despite marked pain", 4 = "I manage to do it, despite the pain, but only if I have help", 5 = "I cannot do it at all, because of the pain". NOTE: Only fill in areas that are affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing ___	Drying hair ___	Brushing teeth ___	Putting on shoes ___	Preparing meals ___	Taking out trash ___
Showering ___	Combing hair ___	Making bed ___	Tying shoes ___	Eating ___	Doing laundry ___
Washing hair ___	Washing face ___	Putting on shirt ___	Putting on pants ___	Cleaning dishes ___	Going to toilet ___

Difficulties with Physical Activities

Standing ___	Walking ___	Kneeling ___	Bending back ___	Twisting left ___	Leaning back ___
Sitting ___	Stooping ___	Reaching ___	Bending left ___	Twisting right ___	Leaning left ___
Reclining ___	Squatting ___	Bending forward ___	Bending right ___	Leaning forward ___	Leaning right ___
Standing for long periods ___		Sitting for long periods ___	Walking for long periods ___		Kneeling for long periods ___

Difficulties with Functional Activities

Carrying small objects ___	Lifting weights off floor ___	Pushing things while seated ___	Exercising upper body ___
Carrying large objects ___	Lifting weights off table ___	Pushing things while standing ___	Exercising lower body ___
Carrying brief case ___	Climbing stairs ___	Pulling things while seated ___	Exercising arms ___
Carrying large purse ___	Climbing inclines ___	Pulling things while standing ___	Exercising legs ___

Difficulties with Social and Recreational Activities

Bowling ___	Jogging ___	Swimming ___	Ice Skating ___	Competitive Sports ___	Dating ___
Golfing ___	Dancing ___	Skiing ___	Roller Skating ___	Hobbies ___	Dining out ___

Difficulties with Travelling

Driving a motor vehicle ___	Riding as a passenger in a motor vehicle ___	Riding as a passenger on a train ___
Driving for long periods of time ___	Riding as a passenger on an airplane ___	Riding as a passenger for long periods ___

Use the following 1 to 5 scale to describe the difficulties below:
1 = "This area is not affected by my condition", 2 = "This area is slightly affected by my condition", 3 = "My condition moderately restricts my ability in this area", 4 = "My condition seriously limits my ability in this area", 5 = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating ___ Hearing ___ Listening ___ Speaking ___ Reading ___ Writing ___ Using a keyboard ___

Difficulties with the Senses

Seeing ___ Hearing ___ Sense of touch ___ Sense of taste ___ Sense of smell ___

Difficulties with Hand Functions

Grasping ___ Holding ___ Pinching ___ Percussive movements ___ Sensory discrimination ___

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep ___ Being able to participate in desired sexual activity ___

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ☐ I have NOT had prior symptoms similar to my current complaints.
- ☐ My current complaints DID exist before, but have not been bothering me.
- ☐ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ☐ My history HAS contributed to my current symptoms.
- ☐ My history HAS NOT contributed to my current symptoms.
- ☐ I'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (if applicable) occured ___ ☐ months ago / ☐ years ago Or on Date: ___/___/___

Write in below any other Prior Symptom History, not covered above:

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type

☐ Car ☐ Station Wagon
☐ Van ☐ Pickup Truck
☐ Large Truck ☐ Bus
Other_____

2. Your position in vehicle

☐ Driver ☐ Front Passenger
☐ Left Rear Passenger
☐ Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?

☐ Stopped at intersection ☐ Stopped in traffic ☐ Stopped at light
☐ Making a right turn ☐ Making a left turn ☐ Parking
☐ Proceeding along ☐ Slowing down ☐ Accelerating
Other_____

4. Time/Speed/Damage

Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph

5. Details of Accident

Visibility at time of accident
☐ Poor ☐ Fair ☐ Good

Who hit who/what?
☐ You hit other vehicle
☐ Other vehicle hit you
You hit...(object)
_____

6. Road conditions

Road conditions at time of accident
☐ Icy ☐ Wet ☐ Sandy ☐ Dark ☐ Clean and dry

Point of Impact
☐ Head-On ☐ Left Front ☐ Right Front
☐ Read-End ☐ Left Rear ☐ Right Rear

7. Body Position, etc.

Did you see the accident coming: Yes☐☐ No
Were you braced for the impact? Yes☐☐ No
Did you have a seat belt on? Yes☐☐ No
Did you have a shoulder harness on? Yes☐☐ No

Does your vehicle have headrests? Yes☐☐ No
What was the position of your headrest at the time of the impact?
☐ Even with top of head ☐ Even with bottom of head ☐ Middle of neck
What was the direction of your head at the time of the impact?
☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left

Did driver side air bags deploy? Yes☐☐ No Did passenger side airbags deploy? Yes☐☐ No Did side airbags deploy? Yes☐☐ No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike the inside of your vehicle? Yes☐☐ No
If yes, describe:_____
Did you lose consciousness during the injury? Yes☐☐ No
If yes, for how long? _____

Did police show up at the scene? Yes☐☐ No
Was an accident report filled out? Yes☐☐ No

10. After the accident:

Check off your symptoms right after and a few days following:

☐ Headache ☐ Dizziness ☐ Mid back pain ☐ Cold hands
☐ Neck pain ☐ Nausea ☐ Low back pain ☐ Cold feet
☐ Neck stiffnes ☐ Confusion ☐ Nervousness ☐ Diarrhea
☐ Fainting ☐ Fatigue ☐ Loss of taste ☐ Depression
☐ Ringing in ears ☐ Tension ☐ Toe numbness ☐ Anxious
☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain
☐ Pain behind eyes ☐ Shortness of breath ☐ Sleeping problems
Others:_____

11. Emergency Room?

Where did you go after the accident?
☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor
How did you get there?
☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police
Were X-rays done? Yes☐☐ No **Was lab work done?** Yes☐☐ No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ☐ Cervical Collar ☐ Ice **Other:**_____
Medications:_____
Follow-up instructions:_____
_____

12. Treatment History:

Fill in any other doctor(s) seen prior to your first visit to this office
1. Dr._____ First visit date: ___/___/___
Specialty:_____ X-rays done? Yes☐☐ No
Types of treatments received:_____
How many treatments received? ____ Currently treating? Yes☐☐ No
Did treatments benefit you? Yes☐☐ No
Last visit date: ___/___/___
2. Dr._____ First visit date: ___/___/___
Types of treatments received:_____
How many treatments received? ____ Currently treating: Yes☐☐ No
Did treatments benefit you? Yes☐☐ No
Last visit date: ___/___/___

(PLEASE PRINT)

DATE_____DATE OF INURY _____

FIRST NAME_____LAST NAME _____

ADDRESS_____CITY/STATE/ZIP_____

HOME PHONE _____CELL PHONE _____WORK PHONE _____

DOB: _____AGE_____SEX: M / F MARITAL STATUS: S M D W

DRIVER'S LICENSE # _____SOCIAL SECURITY#_____

OCCUPATION_____EMPLOYEED BY_____

REFERRED BY_____E-MAIL ADDRESS_____

HAVE YOU EVER HAD CHIROPRACTIC CARE BEFORE? _____

PRIMARY INSURANCE_____ MEMBER ID: _____

ADDRESS_____ GROUP #: _____

INURED'S NAME_____RELATION _____SS#_____

SECONDARY INSURANCE_____ MEMBER ID: _____

ADDRESS_____ GROUP #: _____

INURED'S NAME_____RELATION_____SS#_____

AUTO ACCIDENT (FILL OUT)

IS THIS INJURY/ILLNESS REALTEDTO AN AUOTMOBILE ACCIDENT? Y / N

AUTO INSURANCE CO. _____POLICY#_____CLAIM#_____

AGENTS NAME_____ PHONE#_____ADDRESS_____

NAME OF ATTORNEY_____ PHONE#_____

ADDRESS_____

WORK INJURY (FILL OUT)

IS THIS INJURY/ILLNESS WORK-RELATED? Y / N HAVE YOU REPORTED IT TO YOUR EMOPLOYER? Y / N

CLAIM#_____

AGENTS NAME_____ PHONE#_____ADDRESS_____

NAME OF ATTORNEY_____ PHONE#_____

ADDRESS_____

Total Health Medical Center, PC

12106 Old Line Center
Waldorf, MD 20602
(301) 645-8898

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Total Health Medical Center. PC

12106 Old Line Center
Waldorf MD 20602

NOTICE OF PRIVACY PRACTICES

Total Health Medical Center, PC will use and disclose your personal health information to treat you. To receive payment for the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, and have copies available for distribution.

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Total Health Medical Center, PC to furnish medical care and treatment to me considered necessary and proper in diagnosing or treating his/her physical and mental condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefit to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to Total Health Medical Center, PC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary including medical records, to secure payment.

FINANCIAL POLICY STATEMENT

We verify your insurance benefits as a courtesy to you. However, Total Health Medical Center, PC does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plans. We require that any co-pays that are due be paid at each visit. Once your insurance carrier processes your claim we will bill you for any remaining patient responsibility deemed by your insurance carrier. If your Insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Total Health Medical Center, PC. The above may not apply for those patients that are considered Worker's Compensation, Medicare Primary or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check you expressly authorize Total Health Medical Center, PC, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the ruled of the National Automated ClearingHouse Association, you may call (888) 235-4635 to revoke the authorization for the electronic transition. This does not, however mean that Total Health Medical Center, PC cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Patient/Legal Guardian/Responsible Party Signature **Date**

Clinic Representative Initials_____

PATIENT HISTORY

Date _____

Patient's Name _____ Date of Birth _____ Age _____

Occupation _____

Marital Status: S M W D Ethnic Origin _____

Last Year of School Completed _____

Allergies

Medicinal	Other

Current Medications	Recurrent Problems

Tests & Immunizations

Blood Profile _____

Breast Exam _____

Breast Mammography _____

CBC _____

Chest X-Ray _____

Cholesterol Triglycerides _____

Complete Physical _____

EKG _____

Enlarged Heart _____

Flu Shot _____

Genitalia Exam (Male) _____

Hearing Test _____

HIV Test _____

PAP Smear (Women) _____

Pneumonia Vaccine _____

Pulmonary Function _____

Rectal Exam _____

Sigmoidoscopy _____

Sodium & Potassium _____

Stool Occult Blood _____

Tetanus (DPT) _____

Treadmill Test _____

Urinalysis _____

Vision Test _____

Other _____

Total Health Medical Center, PC
12106 Old Line Centre
Waldorf, MD 20602
301-645-8898

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PERSONAL HISTORY

PERSONAL/FAMILY HISTORY

Number of Siblings

PERSONAL	YES	WHEN	NO	FAMILY	YES	SPECIFIC MEMBER	NO
Abdominal bleeding							
Allergies							
Anemia							
Arthritis							
Asthma/Emphysema							
Back Disorders							
Backache							
Black Tarry Stools							
Bleeding Diseases							
Blood in Stool							
Blood in Urine							
Cancer							
Change in Bowel habits							
Chest Pain							
Colitis							
Constipation							
Convulsion							
Cough							
Coughing Blood							
Depression							
Diabetes							
Diarrhea							
Difficulty Swallowing							
Dizziness							
Double Vision							
Enlarged Heart							
Epilepsy							
Fainting Spells							
Gallstones							
Gall Bladder Disorder							
Glaucoma							
Headaches							
Heart Disease							
Heart Murmur							
Hepatitis							
Hoarseness							
High Blood Pressure							
Indigestion							
Irregular Heart Beat							
Kidney Infection							
Kidney Stone							
Leg Pain							
Lung Disease							
Lyme Disease							
Nocturia							
Nosebleeds							
Nervous Disorder							
Painful Urination							
Paralysis							
Phlebitis							
Pleurisy							
Pneumonia							
Pus in Urine							
Rheumatic Fever							
Shortness of Breath							
Stroke							
Swelling of feet							
Swollen/Painful Joints							
T.B.							
Thyroid Disease							
Ulcer							
Venereal Disease							
Vomited Blood							
Other							

PATIENT HISTORY

Personal Habits

Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential.
Please rate your answer on a scale of 1 to 5 (1 = No/Never, 5 = Yes/Often.)

	1	2	3	4	5	Elaborate
Exercise Regularly (3 to 4 x WK)						
Wear Seat Belts						
Use Drugs						
Drink Alcohol						
Smoke						
Chew Tobacco						
Experience Stress						
Other						

WOMEN ONLY

Menstrual Periods: Age Onset _____ Regular? _____ Date Last Period Began _____
Age Menopause _____
Difficulty with Periods? ☐ Yes ☐ No Specify _____
Pregnancies: No. of Children: Born Alive_____ Cesarean_____ Premature_____ Stillborn_____ Miscarriages_____

Describe complications: _____

Have you ever been referred to a specialist? ☐ Yes (Please Elaborate) ☐ No

Have you ever been in an accident? ☐ Yes (Please Elaborate) ☐ No

Are there any environmental risks involved in your job or home environments? ☐ Yes (Please Elaborate) ☐ No

MILITARY SERVICE

Which branch of service did you serve in? _____
Length of enlistment: _____ From: _____ To: _____
Did you sustain any injuries? ☐ Yes (Please Elaborate) ☐ No

Total Health Medical Center, PC
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Waldorf, MD 20602
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PATIENT HISTORY

OPERATIONS

Tonsillectomy _____	Complications _____	Date _____
Appendectomy _____	Complications _____	Date _____
Hernia Repair _____	Complications _____	Date _____
Other _____	Complications _____	Date _____
Cholecystectomy _____	Complications _____	Date _____
Hysterectomy _____	Complications _____	Date _____
Hemorrhidectomy _____	Complications _____	Date _____
Other _____	Complications _____	Date _____
Radiation therapy _____	Where _____	Date _____

HOSPITALIZATIONS

	Description	Hospital	Year
Illness (Kind)			
Surgery (Kind)			
Other (Reason)			

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance.

DOCTOR'S LIEN

TO: ATTORNEY FROM: TOTAL HEATH MEDICAL CENTER, PC

ADDRESS:

12106 OLD LINE CENTRE
WALDORF MD 20602
(301)-645-8898

PHONE: _____

RE: REPORTS AND DOCTOR'S LIEN

I DO HEREBY ATHORIZE, TOTAL HEALTH MEDICAL CENTER, PC TO FURNISH YOU, MY ATTORNEY, WITH A FULL REPORT OF THEIR EXAMINATION, DIAGNOSIS, TREATMENT, PROGNOSIS, ECT., OF MYSELF IN REGARDS TO THE ACCIDENT IN WHICH I WAS INVOLVED.
I HEREBY AUTHORIZE AND DIRECT YOU, MY ATTORNEY, TO PAY DIRECTLY TO TOTAL HEALTH MEDICAL CENTER, PC. SUCH SUMS AS MAY BE DUE AND OWING TOTAL HEALTH MEDICAL CENTER, PC FOR MEDICAL SERVICE RENDERED ME BY REASON OF THIS ACCIDENT AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT TOTAL HEALTH MEDICAL CENTER, PC. I HEREBY FURTHER GIVE A LIEN ON MY CASE TO TOTAL HEALTH MEDICAL CENTER, PC. AGAINST ANY AND ALL PROCEEDS OF ANY SETTLEMENT, JUDGMENT OR VERDICT WHICH MY BE PAID TO YOU, MY ATTORNEY, OR MYSELF AS THE RESULT OF THE INJURIES FOR WHICH I HAVE BEEN TREATED OR INJURIES IN CONNECTION THEREWITH. **I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO TOTAL HEALTH MEDICAL CENTER, PC FOR ALL MEDICAL BILLS SUBMITTED BY THEM FOR SERVICE RENDERED ME AND THAT THIS AGREEMENT IS MADE SOLELY FOR TOTAL HEALTH MEDICAL CENTER, PC ADDITIONAL PROTECTION AND IN CONSIDERATION OF THEIR AWAITING PAYMENT.** AND I FURTHER UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGMENT OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEE.

PATIENT'S SIGNATURE:	**DATE:**
PATIENTS'S NAME(PRINT)	**DATE:**
DATE OF ACCIDENT:	

THE UNDERSIGNED BEING ATTORNEYS OF RECORD FOR THE ABOVE PATIENT DOES HEREBY AGREE TO ABSERVE ALL THE TERMS OF THE ABOVE AND AGREES TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGMENT OR VERDICT AS MAY BE NECESSARY TO ADQUATELY PROTECT TOTAL HEALTH MEDICAL CENTER, PC

ATTORNEY'S SIGNATURE:	**DATE:**

ATTORNEY: PLEASE SIGN AND RETURN ONE COPY TO ABOVE ADDRESS.