# Welcome to the office of Dr. Anne Sorrentino

## New Patient Information

Date

First Name Last Name

Address

City State Zip

Cell phone Home phone

Email

Age DOB M F

Occupation

Employer

Emergency Contact Relationship to you

Cell phone Home Phone

Address

City State Zip

**OUR MISSION**

**Reduce Pain-Prevent Injury-Improve Performance**

**McLean Professional Park 1485 Chain Bridge Rd Suite 105 McLean, VA 22101**

**724-840-3443**

# MEDICAL HISTORY FORM

**Name:** _____ **Age:** _____ **Date of Birth:** _____ **Date:** _____

## I. PAST MEDICAL HISTORY

**a. Surgeries**

i. Type: _____ Date Performed: _____
ii. Type: _____ Date Performed: _____
iii. Type: _____ Date Performed: _____
iv. Type: _____ Date Performed: _____

**b. Fractures**

i. Type: _____ Date Performed: _____
ii. Type: _____ Date Performed: _____
iii. Type: _____ Date Performed: _____
iv. Type: _____ Date Performed: _____

**c. ER Visits**

i. Type: _____ Date Performed: _____
ii. Type: _____ Date Performed: _____
iii. Type: _____ Date Performed: _____

## II. FAMILY HISTORY

a. Mother: Age *(if living)* _____ Age *(at death)* _____ Cause of death
List any medical Problems she had or lived with: _____

b. Father: Age *(if living)* _____ Age *(at death)* _____ Cause of death
List any medical Problems he had or lived with: _____

c. Other Blood Relatives: _____ Relationship _____ Conditions
d. Other Blood Relatives: _____ Relationship _____ Conditions

## III. LIFESTYLE HISTORY

a. Have you ever been pregnant? Yes q No q N/A q
*If yes, how many births?* _____ Cesarean Birth? Yes q No q *Any complications:* _____
b. Smoking Status: q Unknown q Every Day q Former Smoker q Never Smoked q Unknown if ever smoked
q Heavy Smoker q Light Smoker *When you Quit:* _____ *Date*
*c.* Do you drink alcohol? Yes q No q *(If yes how much?* _____ *how often?* _____ *)*
d. Do you take street or recreational drugs? Yes q No q
e. Do you currently take medications? Yes No q *What are the medications?* _____
f. Herbal or Dietary Supplements? Yes q No q *What are the supplements?* _____
g. Number of meals per day: _____ *Number of "fast food" meals per week?* _____
*h.* Exercise Regularly? Yes q No q *how long?* _____ *how often?* _____ *)*
i. Are you employed or self employed? Yes q No q
j. Have you had any work-related illness or injuries? Yes q No q
*If ye,s please explain:* _____ *Injury/Illness* _____ *Date*
k. Are there any Hobbies you do or would like to do that are affected by your condition? Yes q No q
1) Hobby: _____ How much: Mildly q Moderately q Significantly q Cant Do q
2) Hobby: _____ How much: Mildly q Moderately q Significantly q Cant Do q
l. Are there any daily activities that you do or need to do that are affected by your condition? Yes q No q
1) Activity: _____ How much: Mildly q Moderately q Significantly q Can't Do q
2) Activity: _____ How much: Mildly q Moderately q Significantly q Can't Do q

## IV. PAST OR PRESENT MEDICAL CONDITIONS

a. Have you had or presently have any of the following conditions? *(Please check and date)*

| CONDITION | DATE(s) | CONDITION | DATE(s) |
|---|---|---|---|
| **Musculoskeletal:** | | **Blood/Immune System** | |
| q Neck pain | | q High cholesterol/triglycerides | |
| q Mid back pain | | q High glucose | |
| q Low back pain | | q Hypothyroidism | |
| q Head Aches q Mild q Mod. q Severe q Daily q Weekly q Monthly | | q Diabetes q Allergies | |
| q Numbness/Tingling q Arm q Hands q Thighs q Leg q Foot | | q Sinus Infections q Ear Infections | |
| q Foot/Ankle Pain | | **Digestive System:** | |
| q Hip Pain | | q Acid Reflux/GERD | |
| q Knee Pain | | q Peptic ulcer *(gastric/duodenal)* | |
| q Elbow Pain | | q Constipation | |
| q Carpal Tunnel | | q Irritable bowl syndrome | |
| q Dizziness | | q Nausea | |
| q Arthritis | | q Vomiting | |
| q Rheumatoid Arthritis | | | |
| q Sciatica | | **Vasculature:** | |
| q Herniated/Degenerated Disc Condition | | q Varicose veins | |
| q Fibromyalgia | | q Blood clots | |
| q Ear Aches | | q Stroke/TIA | |
| q Abnormal X-Ray or MRI findings | | q Peripheral Artery Disease (PAD) | |
| q Shoulder Pain | | q Hardening of the arteries | |
| q Wrist Pain | | | |
| **Heart:** | | **Lungs:** | |
| q High blood pressure | | q Pneumonia | |
| q Heart Attack | | q Asthma | |
| q Angina | | q Bronchitis | |
| q Congestive heart failure | | q COPD | |
| **Nervous system:** | | q Emphysema | |
| q Neuralgia | | | |
| q Migraines | | **Other Conditions:** | |
| q Cluster Headaches | | q Chest pressure/tightness with exertion | |
| q Pinched nerves | | q Chest pressure/tightness with rest | |
| q Depression | | q Generalized weakness | |
| q Panic Attacks/Anxiety | | q Cancer: Type: | |
| | | q Night Sweats | |
| **Organ System:** | | q Trouble breathing | |
| q Kidney Stones | | q Feeling faint or passing out | |
| q Gallstones | | q Pain in legs while walking | |
| q Hepatitis | | q Recent Weight loss: # pounds lost | |
| q Bladder infections | | q Recent weight gain: # pounds gained | |
| q Enlarged Prostate | | q Swollen feet or ankles | |

**List any other problems not mentioned above:** _____

## V. HEALTH MAINTENANCE

Primary Care Physician: _____

**Males**

a. Date of last physical exam: _____
b. Date of last blood test: _____
c. Date of last prostate check: _____

**Females**

a. Date of last physical Exam: _____
b. Date of last blood test: _____
c. Date of last bone density Exam: _____
d. Date of last Breast exam: _____

# New Patient Intake Form

Dr. Anne Sorrentino 1485 Chain Bridge Rd Suite 105 McLean VA 22101

Chief Complaint(s): _____

When did the problem start: _____

What makes it better? _____

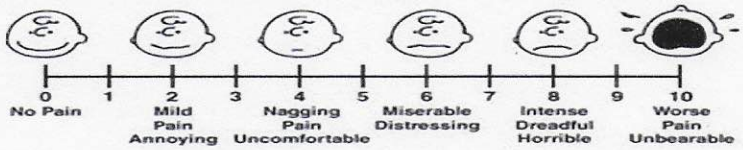
What makes it worse? _____

Quality of Pain: Circle the words that best describe your pain or symptoms:

| | | | |
|---|---|---|---|
| Dull Achy | Stiffness | Sharp/Stabbing | Tightness/Spasms |
| Tingling/Numbness | Burning | Shooting | Can't Describe |

Does it radiate and to where if so? _____

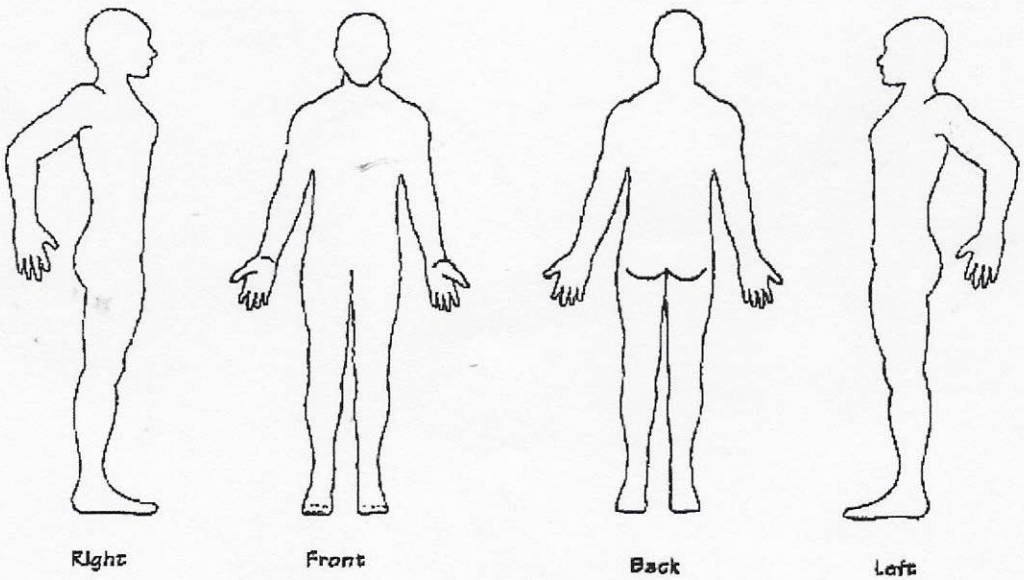
Put a mark to indicate the intensity of pain or symptoms on the scale below:




Circle the phrase that best describes how often you have your symptoms or complain: (Circle One)

INFREQUENTLY SOME OF THE TIME

MOST OF THE TIME ALL OF THE TIME




Patient Signature: _____ Date: _____

# Dr. Anne Sorrentino, D.C., DACBSP®

*DOCTOR OF CHIROPRACTIC*

*DIPLOMATE AMERICAN CHIROPRACTIC BOARD SPORTS PHYSICIANS*


## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

**Name(s) and Address(es) of Office or Clinic**
1485 Chain Bridge Rd Suite 105
McLean VA 22101.

**Print Name(s) of Doctor(s) Treating this Patient**
Dr. Anne Sorrentino

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

_____

Printed name of Patient

_____ _____

Signature of Patient — Date

_____ _____

Signature of Patient's Representative (if minor or physically incapacitated) — Date

_____ _____

Witness to Patient's Signature — Date

# Dr. Anne Sorrentino, D.C., DACBSP®

*DOCTOR OF CHIROPRACTIC*

*DIPLOMATE AMERICAN CHIROPRACTIC BOARD SPORTS PHYSICIANS*

****PLEASE KEEP THIS PAGE FOR YOUR OWN RECORDS****

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

**As part of my health care, Dr. Anne Sorrentino, creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.**

**I understand that this information serves as a basis for my continuing care.**

**I understand that this information is used as a means of communication between Dr. Anne Sorrentino and with medical personnel outside of this practice.**

**I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.**

**I understand that this information is a way for third party insurance companies to assure that a service we bill for was actually performed.**

**I understand that this information can be used as a tool to assess the quality of care provided to patients.**

**I have been provided an opportunity to review the Notice of Privacy Practices for Dr. Anne Sorrentino that provides a more complete review of information used and disclosures.**

**I understand that I have the right to review this Notice of Privacy Practice before signing this consent.**

**I understand that Dr. Anne Sorrentino may change the Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of the office.**

**I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Dr. Anne Sorrentino is not required to agree to the restrictions requested. The procedures to request restriction on information used and disclosure is contained in the Notice of Privacy Practices.**

**I Acknowledge that I have received a copy of the Notice of Privacy Practices of Dr. Anne Sorrentino and agree to the liability limitations explained therein.**

_____ _____ _____

**Signature of Patient or Legal Representative.** **Date** **Relationship to Patient**

_____

**Printed Name of Patient**

**Effective Date January 19, 2016**