



## DeMaio Family Chiropractic & Physical Therapy

*Aligning Your Body's  
Health & Well-being  
... since 1990*

### *Welcome to DeMaio Family Chiropractic*

You have just taken the first step toward improving your health. At DeMaio Family Chiropractic we take pride in delivering the finest care available. Each patient will receive our personal and undivided attention. We will work closely with other physicians and healthcare professionals to assure the most complete and comprehensive health care.

In order to reach optimum wellness we ask that you strictly adhere to all prescribed treatment plans that can include home exercises, supplements, rehabilitation, and follow up visits with any recommended physicians.

***Scheduling...*** We welcome you and look forward to the opportunity in providing you with the superb clinical expertise and the compassionate care we offer. Our staff will try to accommodate all of your needs and make this a positive experience. Patients are generally seen in the office by appointment only, but we usually can accommodate same day appointments. You may call the office with questions or make an appointment.

We ask that all patients:

- Keep all prescribed appointments. If you need to cancel an appointment please give 24 hours notice prior to your appointed time. We do charge \$25.00 to patients who do not give us appropriate amount of time when canceling an appointment.
- If you must cancel, always reschedule the appointment as soon as possible to delay your progress in your treatment plan.
- Please provide our office with a complete medical history and all insurance information. We appreciate that you keep the office posted of any changes in insurance.

If you have any concerns or changes please inform one of our qualified staff members and we will be happy to assist you. Our physicians are readily available, you may call the office during the day and their cell during non-office hours.

### **As a Convenience to you:**

- We Accept Visa, MasterCard & Discover cards
- We have **Multiple convenient locations** to serve you
- We offer modern, comfortable environments
- We are handicapped accessibility
- We provide prompt progress reports

**Dr. John V. DeMaio, D.C., C.C.N.**

**Dr. James Lindauer, D.C.**

**The Village at Waugh Chapel:** 2654 Brandermill Blvd., Gambrills, MD 21054

**PHONE: 410-721-2222** FAX: 410-721-2437

**Maryland Science and Technology Center:** 17000 Science Dr., Ste 204, Bowie, MD 20715

**PHONE: 301-262-4545** FAX: 301-262-7922



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### Learned About DeMaio and Referred By:

AD  Internet  Yellow Pages  Community Event  Friend or Family: \_\_\_\_\_  
 Physician: \_\_\_\_\_  Attorney: \_\_\_\_\_

### Patient Information

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Best Way to reach me is:  Home  Cell  Work  Email

In Case of Emergency, Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Contact Number Home \_\_\_\_\_ Cell Number \_\_\_\_\_

Status:  Single  Married  Divorce  Widowed  Separated  Male  Female

Birthday: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

Parents Name if a Minor: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

# of Children: \_\_\_\_\_ Names: \_\_\_\_\_

### Insurance

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance ID Number: \_\_\_\_\_

Group/Claim Number: \_\_\_\_\_ Additional Coverage  Yes  No

2<sup>nd</sup> Insurance company: \_\_\_\_\_ Subscriber # & Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Group #: \_\_\_\_\_

### Accident Information

Is your condition due to an accident?  No  Yes Date: \_\_\_\_\_ Type:  Auto  Home  Work Comp

Reported Accident to:  Auto Insurance  Workers Comp  Employer  Insurance  Attorney

Attorney's Name: \_\_\_\_\_

Personal Injury Carrier: \_\_\_\_\_ Claim #: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ State of Accident: \_\_\_\_\_

Work Comp Contact: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Have you lost time from work?:  Yes  No How much: \_\_\_\_\_

Has the accident caused you to be disabled?  Yes  No Disability Dates: \_\_\_\_\_ to \_\_\_\_\_

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Health History**

What other treatments have you had for this condition:

- Chiropractic
- Orthopedic
- Neurologist
- PT
- Medication
- Surgery
- Massage

Name of other physicians who have treated you for this condition: \_\_\_\_\_

Previous Chiropractic Care:  No  Yes Date: \_\_\_\_\_  Local  Out of State: \_\_\_\_\_

Date of Last: Physical Exam: \_\_\_\_\_ Spinal X-ray: \_\_\_\_\_ MRI: \_\_\_\_\_

Spinal Exam: \_\_\_\_\_ Dental X-ray: \_\_\_\_\_ CT Scan: \_\_\_\_\_

Medications: \_\_\_\_\_

Vitamins/Herbs/Minerals: \_\_\_\_\_

Females: Pregnant  Yes  No Beginning of last menstrual cycle: \_\_\_\_\_

Check any of the following conditions you have had:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV          | <input type="checkbox"/> Ear Ringing        | <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Earache          |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Anxiety/Depression   | <input type="checkbox"/> Headaches        |
| <input type="checkbox"/> Poor Circulation  | <input type="checkbox"/> Arm/Shoulder Pain  | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sciatica         |
| <input type="checkbox"/> Bladder Problems  | <input type="checkbox"/> Hemorrhoids        | <input type="checkbox"/> Shingles             | <input type="checkbox"/> Sinus Infection  |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Herniated Disk     | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Chronic Fatigue   | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Irregular Cycle      | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Deafness          | <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Leg Pain             | <input type="checkbox"/> TMJ              |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Allergies: _____   |   |   |

Smoking: Packs/Day: \_\_\_\_\_  Alcohol: Drinks/Week: \_\_\_\_\_

Coffee/Caffeine: Cups/Week: \_\_\_\_\_  High Stress Level: Reason: \_\_\_\_\_

Do you Wear:  Heel Lifts  Orthotics  Arch Supports  Other prosthetics \_\_\_\_\_

**Exercise:**  None  Moderate  Daily  Heavy

Have you had any: \_\_\_\_\_ Description \_\_\_\_\_ Dates \_\_\_\_\_

Auto Accidents: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Broken Bones: \_\_\_\_\_

Falls/Head Injuries: \_\_\_\_\_

**Health Goals**

- I am looking for a minimal amount of care to "patch up the symptoms" of my problem and just make the pain stop.
- I am looking to resolve my symptoms and then go onto "fix the cause" of my problem so it won't return. I want to learn how I can limit the damage I do to my body with everyday activities.
- I am looking to take care of my problem and then go onto "achieve optimal health and wellness", so I can enjoy life to its fullest. I want to maintain my health.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_



# DeMaio Family Chiropractic & Physical Therapy

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Patient Name \_\_\_\_\_ Chart # \_\_\_\_\_

Please mark the location of your pain along with the accurate description:

For sharp stabbing pain | | | | | | | | | |

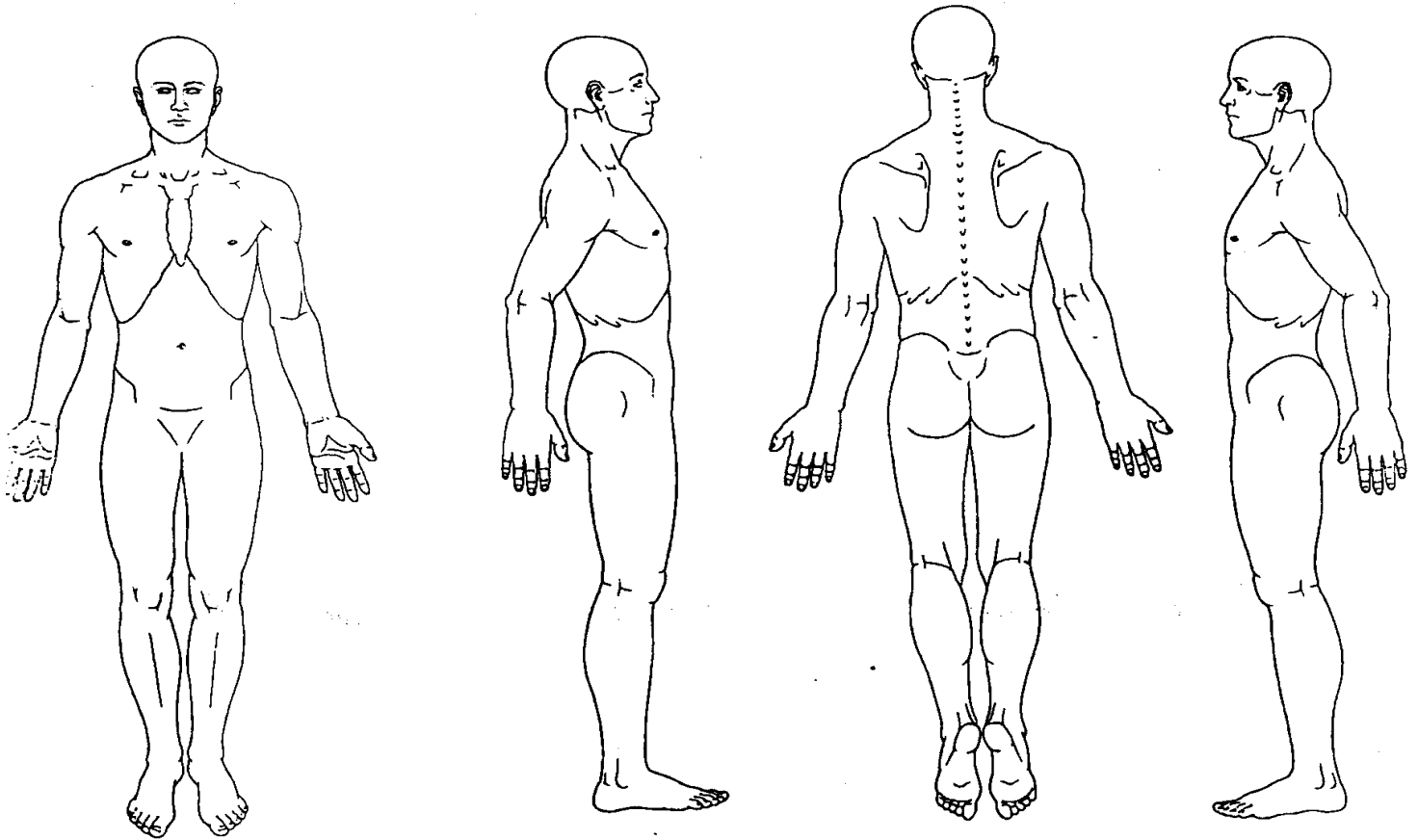
Cramping: ^ ^ ^ ^ ^ ^ ^ ^

Numbness =====

Burning xxxxxxxx

Tingling ::::::::::::::

Dull #####



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Initial Patient Questionnaire – Alternative Medicine Integration

DOB \_\_\_\_\_ Today's Date \_\_\_\_\_ SS# \_\_\_\_\_

Patient Name \_\_\_\_\_

Please check all the areas you are having pain right now

- Neck                       Upper Back / shoulders                       Arm/hand                       Headache                       Mid Back
- Low Back                       Buttock/hip                       Leg/foot                       Other \_\_\_\_\_

If you have more than one area of pain please answer the questions on this form to the area that is HURTING you the most.

Rate your pain when it is at its best.

0(no pain)    1    2    3    4    5    6    7    8    9    10 (Unbearable Pain)

Rate your pain RIGHT NOW

0(no pain)    1    2    3    4    5    6    7    8    9    10(Unbearable Pain)

Rate your pain when it is the worst.

0(no pain)    1    2    3    4    5    6    7    8    9    10(Unbearable Pain)

Which of the following statements **best** describes your pain?

- Dull achy nagging pain                       Dull achy nagging pain that is occasionally sharp or stabbing
- Mostly Sharp or stabbing                       Mostly sensations of burning, numbness or pins and needles

Which of the following statements **best** describe the location of your pain?

- The pain is localized to the neck, head (if headache) or back
- The pain is localized to the neck, head or back but **occasionally** radiates or travels into my shoulder, upper back or upper arm, but not below my elbow below or radiates or travels into my buttock, hip or leg but not below my knee.
- The pain radiates or travels **most of the time** into my shoulder, upper back or upper arm, but not below my elbow or travels into my buttock, hip or leg but not below my knee.
- The pain radiates or travels below my elbow or knee

Which of the following statements best describe the frequency of the pain?

- Intermittent:** The Pain occurs less than one fourth of the time when I am awake.
- Occasional:** The Pain occurs between one fourth and one half of the time that I am awake.
- Frequent:** The Pain occurs between one half and three fourths of the time that I am awake.
- Constant:** The Pain occurs between three fourths and all the time I am awake.

How Long have you had the pain?

- Less than 6 weeks                       6 weeks to 3 months                       3 – 12 months                       Greater than 12 months

How many times in the past have you had the same or similar pain or problem?

- 0     1-2     3-4     5 or more

Patient Signature \_\_\_\_\_

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**Informed Consent, Benefits, Risks, and Treatment Options**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various physical therapies on me (or the patient for whom I am legally responsible) by licensed doctors and staff of DeMaio Family Chiropractic who are now or in the future employed by DeMaio Family Chiropractic. I have had an opportunity to discuss with the physician the nature and purpose of chiropractic adjustments and other procedures. I understand that prior to establishing a treatment plan the physician must perform an examination in order to determine the exact cause of the complaint. During this examination the physician will perform some procedures intended to reproduce symptoms, which will allow for better understanding of the nature of my condition. There is a possibility that this exam may temporarily aggravate my symptoms. I also understand that results are not guaranteed. All patient care, including chiropractic care, has the potential for adverse effects.

I understand that the risks associated with chiropractic care include, but are not limited to fractures, disc injuries, strokes, dislocations, and sprains; however these side effects are extremely rare. The most common side effect, following examination and/or treatment is muscle soreness. I do not expect the physician to be able to anticipate and explain all risks and complications, and I wish to rely upon the physician to exercise judgment during the course of treatment and/or procedure, based upon the facts known to him/her. Some chiropractic adjustments may cause a "popping" sound which is related to a gas and fluid exchange between the joint surfaces. In addition to chiropractic care, there may be other treatment options for my condition. These may include: self-administered care (ie over the counter analgesics, rest, ice, etc), medical care & prescription drugs, physiotherapy, hospitalization and/or surgery. If I choose to use one of the fore-mentioned "other treatment" options, I am aware that there are risks of such options and I may want to discuss this with my primary care physician.

I have read, or read to me the above consent. I have had the opportunity to ask questions regarding it's content and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present and any future condition for which seek treatment.

**NOTICE OF PRIVACY PRACTICES**

I consent to the use of disclosure of my protected health information by DeMaio Family Chiropractic for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my healthcare bills or conduct healthcare operations of a Chiropractor. I understand analysis diagnosis or treatment of me by DeMaio Family Chiropractic may be conditioned upon my consent as evidenced by my signature below. I understand that I have the right to request a restriction as to how my protected health information is used to disclosed to carry out treatment, payment, or healthcare operations of the practice. DeMaio Family Chiropractic is not required to agree to the restrictions that I may request. However, if DeMaio Family Chiropractic agrees to a restriction that I request, the restriction is binding for DeMaio Family Chiropractic. I have the right to revoke this consent in writing at any time, except to the extent that DeMaio Family Chiropractic has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices and understand that I have a right to a copy of this notice prior to signing this document. This notice describes the types of uses and disclosures of my protected health information that can occur in my treatment, payment of my bills or in the performance of healthcare operations. This notice is also posted in the lobby of each office of DeMaio Family Chiropractic. I acknowledge that I have been informed of the Notice of Privacy Practices with an available copy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_