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

Providers	**Assistants**	**Massage Therapist/Acupuncturist**
Joseph A. Pollack, D.C.	Kathryn Gitthens, C.A	Bac Dinh, L.Ac., L.M.T, M.S.O.M.
Ryan J. Mullen, D.C.	Elizabeth Swarcz, P.T.A	
Marshall A. Dispenza, D.C.		
Molly Sullivan, D.P.T		

Office Hours:

Monday/Wednesday: 7:00am - 6:00pm | Tuesday/Thursday: 8:00am - 6:00pm | Friday: 7:00am - 5:00pm

**Please call for provider specific hours*

To Prepare For Your Initial Visit:

Please bring your License/Photo ID, Health Insurance Card(s), Referral(s), and Patient Forms, including this form and the Authorization for Release of Medical Information, Authorization and Consent for Treatment, Financial Policy, Notice of Privacy Practices, and optionally the Preferred Contacts form or the Virtual Visit Policy form. If you have a personal injury claim, please bring claim information including, your claim number, adjuster contact information and hospital discharge papers (if applicable). If you are unable to complete these forms before your appointment date, please plan to arrive at least 20-30 minutes ahead of your appointment time to avoid cutting into your appointment time by filling out forms.

Patients prefer to wear comfortable clothing and shoes to their appointment(s). For acupuncture consider wearing comfortable clothes with buttons that allow the provider to reach areas for treatment.

LOCATION: Our suite is not accessible through the front of the building. Please drive to the left side of the building towards the back entrance for Suite 212. We are marked by a black accessibility ramp and a blue mailbox. Our reserved patient parking is next to the blue mailbox, directly in front of our entrance.

HEALTH SAFETY REQUIREMENTS: If you feel ill, we ask that you reschedule your visit. Please do your best to provide notice before 7:00am on the day of your appointment. Masks are not required, unless you are experiencing symptoms and must come into the office. We ask that you wash your hands after you enter the building. A sink and antibacterial soap are available as you enter the office hallway.

If you have any further questions, we 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 acupuncture, and massage therapy. We look forward to meeting you and helping you restore your health!

Sincerely,

Your Proactive Chiropractic & Physical Therapy Team

Profile Information

Name	
Preferred Name	
Date of Birth *MM/DD/YYYY*	
Sex	▢Female ▢Male ▢ Gender (If Different from Sex):
Phone	
Email	
Address	
Emergency Contact/Phone/Relationship	
Occupation	
Family Doctor	
Referring Provider	
Referred To?	
How did you hear about us?	

Insurance Information

If you plan to use health insurance to supplement your visit, you must fill out all fields below. If you were involved in an accident (auto,work,etc.), please provide your claim information. If your health insurance requires a referral, please bring a referral from a medical doctor. Note, we are out-of-network with Medicaid, Kaiser, and Johns Hopkins, and that Acupuncture is not yet covered by Medicare.

▢ **Not Using Insurance**	
Policyholder’s Name	
Policyholder’s Date of Birth *MM/DD/YYYY*	
Insurance Provider	
Member ID Number	
Group Number	
Relationship to Policyholder	▢**Self** ▢**Spouse** ▢**Child** ▢**Other:**
Secondary Insurance Provider & Member ID	
Secondary Policyholder’s Name & Date of Birth	

Health History

What is the reason that you have come in to see us today? *Required*

List your primary symptoms and how long these have been present. *Required*

Have you had acupuncture before? If so, for what reason? *Required* ▢ Yes ▢ No

What do you hope to achieve? *Required*

Medical History

Are you pregnant or might you be pregnant?*Only Women* ▢ Yes ▢ No

Previous hospitalizations or surgeries? Include dates and diagnosis. *Required*

List Any Major or Chronic Conditions and their Medications *Required*

▢ **Diabetes**	
▢ **High Blood Pressure**	
▢ **Neurological Disease**	
▢ **Heart Disease**	

▢ **Diabetes**	
▢ **Respiratory Disease**	
▢ **Gastrointestinal Disease**	
▢ **Liver Disease or Hepatitis**	
▢ **Cancer**	
▢ **Heart Attack**	
▢ **Kidney Disease**	
▢ **Thyroid Disease**	
▢ **HIV or Other Infectious Disease**	
▢ **Other**	

Other Medical Conditions? *Required*

Sleep

I can't go to sleep until after 11pm. *Required* ▢ True ▢ False

Insomnia: I can go to sleep, but awaken at... *Required*

▢ 11pm to 1am (Gb)
▢ 1am to 3am (Lr)
▢ 3am to 5am (Lu)
▢ 5am-7am (Li)
▢ I don’t have this problem

Fatigue: I have a problem with fatigue. It is worse during… *Required*

▢ 5am-7am (Li)
▢ 7am to 9am (St)
▢ 9am to 11am (Sp)
▢ 11am to 1pm (Ht)
▢ 1pm to 3pm (Si)
▢ 3pm to 5pm (Ub)
▢ 5pm to 7pm (Ki)
▢ 7pm to 9pm (PC)
▢ I don’t have this problem

Emotions: Select the emotions that are most troublesome in your life... *Required*

▢ Irritability ▢ Grief ▢ Sadness or Lack of Joy ▢ Worry ▢ Fear ▢ Anger ▢ N/A

Drug History

List any drugs taken regularly in addition to the ones previously listed: *Required*

List any over the counter supplements or herbs taken regularly: *Required*

Check the following poisons that you use regularly: *Required*

- ▢ Tobacco
- ▢ Alcohol
- ▢ Coffee
- ▢ Caffeinated Tea
- ▢ Street Drugs
- ▢ Nutrasweet
- ▢ Splenda
- ▢ Saccharine
- ▢ Diet Drinks
- ▢ MSG
- ▢ Trans-Saturated Fats/ Partially Hydrogenated Fats
- ▢ Soy
- ▢ Mercury Amalgam Dental Fillings
- ▢ Fluoride Toothpaste

List any known drug allergies: *Required*

Pain

Do you have pain? Describe where. *Required* ▢ Yes ▢ No

Rate your pain on a scale from 1 to 10. Where 10 is the worst pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

Endocrine

Check all that apply *Required*

- ▢ I am gaining weight, no matter what I do
- ▢ My emotions are out of control
- ▢ I have lost my sex drive

Do you still have periods?*Only Women* ▢ Yes ▢ No

Do you have trouble with impotence?*Only Men* ▢ Yes ▢ No

Do you have to get up at night to urinate? *Required* ▢ Yes ▢ No

Family History

List any illnesses that run in your family: *Required*

Review of Systems

List any pertinent history of problems, diagnosis, surgery, etc. involving each of the following along with the dates: *Required*

▢ **Head, Eyes, Ears, Nose, Throat**	
▢ **Cardiovascular**	
▢ **Respiratory**	
▢ **Gastrointestinal**	
▢ **Musculoskeletal**	
▢ **Neurological**	
▢ **Skin**	
▢ **Immune System**	
▢ **Other**	

Existing Markers

Please describe any existing markers; if you do not have any of these, please write N/A.

List any scars, tattoos, piercings and their location and the date received. *Required*

List any spinal anesthesia or spinal taps their location and the date received. *Required*

Dental

Have you had a Root Canal? *Required*

▢ No ▢ Yes. List Tooth Numbers and Date:

▢ Not Sure. Please retrieve this information from my dentist, with this contact information:

Have you had a Crown? *Required*

▢ No ▢ Yes. List Tooth Numbers and Date:

▢ Not Sure. Please retrieve this information from my dentist, with this contact information:

Have you had any Extractions? *Required*

▢ No ▢ Yes. List Tooth Numbers and Date:

▢ Not Sure. Please retrieve this information from my dentist, with this contact information:

Consents

Please complete the additional consents including the Authorization for Release of Medical Information, Authorization and Consent for Treatment, Financial Policy, Notice of Privacy Practices, and optionally the Preferred Contacts form or the Virtual Visit Policy form.*required by our medical group found on our website, the patient portal, or provided by our administrative team.*

Accuracy of Information

☐ *I certify that the above information is correct to the best of my knowledge.* Required

Appointment Notification

I would like to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments via:

☐ Email ☐ Text Message (SMS) ☐ Phone Call

News and Special Promotions

☐ Yes, I would like to receive news and special promotions by email. Including information about our hours of operation, staff changes, new services, office events, and special discounts.

Signature

____ Date: ______________