PROACTIVE
CHIROPRACTIC AND PHYSICAL THERAPY

Thank you for maintaining your health with Proactive Chiropractic and Physical Therapy. We're happy to have your back! The following is some information to refamiliarize you with our practice. Please read and complete this form carefully to help refamiliarize our team with your health.

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 up-to-date 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 your claim information including the 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 15-20 minutes ahead of your appointment time to avoid cutting into your appointment time by filling out forms.

REMINDER: 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 as part of your healthcare team. 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?	

Insurance Information

Please provide information for your current insurance plan. If you were involved in an accident (auto,work,etc.), please provide your claim information. If your health insurance requires a referral, i.e. Medicare for physical therapy, please bring a referral from a medical doctor. Note, we are out-of-network with Medicaid, Kaiser, and Johns Hopkins.

▢ **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	

Medical Information

Please provide information about your current condition and reason for visiting us today.

Chief Complaint

What is the primary reason for your visit today? *Required*

***Please describe the location of your symptoms in detail*

Please rate the severity of your pain. *Please circle one.* *Required*

0 1 2 3 4 5 6 7 8 9 10

***0 is equivalent to no pain at all_____10 is equal to "I need to go to the emergency room"*

Have you experienced shooting pain or numbness/tingling in any of your extremities? If yes, please describe. *Required*

☐ *No* ☐ *Yes*

Was the onset of this issue: *Required*

☐ Specific Incident/Injury ☐ Gradually Worse Over Time ☐ Sudden, But No Incident/Injury

Since onset, has the pain gotten: *Required*

☐ Better ☐ Worse ☐ Stayed the Same

When did this episode begin? *Required*

Is this episode the first time you have experienced this pain? *Required*

☐ *Yes* ☐ *No*

When was the first occurrence of this pain? *Required*

What treatments have you received for this problem in the past? *Required*

Describe the quality of the complaint/pain. *Select all that apply. Required*

☐ Sharp/Stabbing ☐ Dull/Achy ☐ Pulling/Tight ☐ Tingling/Numbness ☐ Burning/Throbbing ☐ Other

On an average day, how often are you aware of your symptoms? *Required*

☐ Intermittent (less than 25% of time) ☐ Occasional (25%-50% of time)

☐ Frequent (50%-75% of time) ☐ Constant (75%-100% of time

The symptoms are: *Select all that apply. Required*

☐ Worse in the Morning ☐ Worse at Night ☐ Better with Activity ☐ Worse with Activity

What activities make the pain worse? *Select all that apply. Required*

☐ Sitting ☐ Standing ☐ Walking ☐ Running ☐ Lifting ☐ Sneezing/Coughing

☐ Specific Movement of Painful Area (Driving, Bending, etc) ☐ Other

What activity do you have the most difficulty with? *Please select all that apply. Required.*

☐ Sitting ☐ Walking ☐ Driving ☐ Lifting ☐ Other

☐ Standing ☐ Running ☐ Climbing stairs ☐ Exercise

What percentage capacity do you feel able to perform the above activity? *Please circle one.*

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

*** 0% is **Unable** to perform selected activity, 100% is **No Limitation** with selected activity.*

Which of these makes your problem better? (check all that apply) *Required. Check all that apply.*

☐ Ice ☐ Heat ☐ Sitting ☐ Standing ☐ Lying down ☐ Walking ☐ Medication ☐ Other

Have you had any changes to your bowel/bladder function? *Required*

☐ Yes ☐ No

Secondary Complaint

Health History

Please list any changes to your health history including any new diagnoses or surgeries.

Please list any recent surgeries with approximate date: *Required*

Please list any new conditions you or any immediate family members have been diagnosed with:
Required. Please briefly elaborate on any history with a brief description (ex. Self or Parent)

Please list any changes in medications, vitamins and supplements? *Required*

Social History

Begun or quit any habits? *Required*

☐ Quit Smoking ☐ Quit Drinking ☐ Now Smoking ☐ Now Drinking ☐ No Changes

How would you describe your stress level recently? *Required*

☐ Mild ☐ Moderate ☐ Severe

Do you perform regular physical activity? *Required*

☐ No ☐ Yes, Please Describe:

Are you currently pregnant? If yes, when is your expected due date? *Required*

☐ *No* ☐ *Yes, Due Date:*

Consents

Please update 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*

Signature

_____ Date: _____