Welcome to

Politis Family Chiropractic, PC

*Date*_______________________ *Signature.*____

PERSONAL DATA

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.
First Name____________________________________**Nick Name**______________________________________
Last Name ___________________________________ **Middle Name** _______________**Suffix** _________
Date of Birth _____/____/________ **Gender** *(check one)* ❑ Male ❑ Female
Address 1 ____
Address 2 ____
City____**State**___________**Zip Code** ________________
Primary Phone ________________________________**Secondary Phone** ___________________________
Mobile Phone ____

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other______________________
Employment Status *(check one)*
❑ Employed ❑ Self Employed ❑ Retired ❑ FT Student ❑ PT Student ❑ Other
Parents names (if you are under 18)

____

Names and Ages of Children ____

Whom may we thank for referring you to our office?_____________________________________

Have you ever received Chiropractic care? ❑ Y ❑ N
Doctor____**Date of last visit**:__________
Why did you discontinue care?

Home email ______________________________ **Work Email** _______________________________

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Preferred Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

On which phones may we leave a message? ❑ Home ❑ Work ❑ Mobile

Verification Question *(check only one question, then give the answer to that question)*

❑ What is the name of your favorite pet?
❑ In what city were you born?
❑ What high school did you attend?
❑ What is your favorite movie?
❑ What is your mother's maiden name?
❑ On what street did you grow up?
❑ What was the make of your first car?
❑ When is your anniversary?

Verification Answer to the Chosen question: ____

Answers must be at least 6 characters long.

Race *(check one)*

❑ White ❑ Asian ❑ Filipino
❑ Black/African American ❑ Asian Indian ❑ Vietnamese
❑ Hispanic ❑ Chinese ❑Samoan
❑ American Indian/Alaskan Native ❑ Japanese ❑ Guamanian or Chamorro
❑ Native Hawaiian or other Pacific Island ❑ Korean
❑Other____________________________❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Other____

HOW CAN WE HELP YOU?

What brings you here?

What do you want to improve?

What other things will that allow you to do?

Please check the choice that most clearly describes your current goals for health and wellbeing.

(Check all that apply):

❒ I am only concerned with my immediate problem

❒ I am only concerned with my immediate problem and preventing its return.

❒ I want optimum health and well-being on every level that is available to me.

HEALTH, WELLNESS AND CHIROPRACTIC CARE

Your health future is most important to us. We will create it together. To help us better understand where you are now and how you got here we need to collect a health history. Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, EMOTIONAL, or CHEMICAL in nature.

Please answer the following questions as accurately and completely as possible.

HISTORY OF PHYSICAL STRESSES (Birth to Present)

Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your recollection how you were birthed:

Was your birth: (check all that apply)

❑ natural ❑ at home ❑ premature ❑ prolonged ❑ forceps

❑ drug induced ❑ in hospital ❑ C section ❑ breech ❑ suction

❑ don't know

Comments:

A great number of physical traumas occur in the early years (between birth and the early twenty's). It is during those years that your spine and nerve system is growing and most impressionable. The information below will help us to see the types of stresses that you have been subjected to.

Have you had any accidents related to the following: (check all that apply and give dates)

❑ automobile (even as a passenger) ❑ motorcycle ❑ bicycle ❑ sports ❑ other ____________

If yes, please explain how and when: ____

____

Have you ever injured your spine (neck, head, back, hips)? ❑ yes ❑ no

If yes, please explain how and when: ____

____

Have you broken any bones or sprained any part of your body? ❑ yes ❑ no

If yes, please explain how and when: ____

____

Have you ever been hospitalized? ❑ yes ❑ no

If yes, please explain how and when: ____

____

HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the emotional stress in our life from the physical response that often

occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	❑ Yes ❑ No	Relationship Stress	❑ Yes ❑ No
Loss of loved one	❑ Yes ❑ No	Financial Stress	❑ Yes ❑ No
Divorce/separation	❑ Yes ❑ No	Illness	❑ Yes ❑ No
Parents divorce	❑ Yes ❑ No	Work / School Stress	❑ Yes❑ No
Lifestyle change	❑ Yes ❑ No	Family Stress	❑ Yes ❑ No
Abuse	❑ Yes ❑ No	Other (please list)	

HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Have you been vaccinated? ❑ yes ❑ no ❑ don't know

Do you or have you ever taken? ❑ prescription drugs ❑ over the counter drugs ❑ recreational drugs

Have you been exposed to? ❑ chemicals ❑ fumes ❑ dust ❑ smoke

Do you consume? ❑ alcohol ❑ coffee/caffeine

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

ü 0 ü 1 ü 2 ü 3 ü 4 ü 5 ü 6 ü 7 ü 8 ü 9 ü 10

No interest *Very Interested*

ADDITIONAL PRESENT STRESSORS

Has any doctor diagnosed you with Hypertension presently? ❑ Yes❑ No If yes, describe:

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No

If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?

❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: ______________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?

❑ Yes ❑ No

Current medications, including frequency and dosage if known. *If there are no current medications, check here:* ❑

1) ______________________________ 5) ______________________________
2) ______________________________ 6) ______________________________
3) ______________________________ 7) ______________________________
4) ______________________________ 8) ______________________________

List any known allergies you have had to any medications.
If no allergies are known, check here: ❑

1) ______________________________ 3) ______________________________
2) ______________________________ 4) ______________________________

Please bring the following with you for your appointment:

1. THIS FORM
2. IDENTIFICATION
3. ALL INSURANCE CARDS
4. READING GLASSES IF YOU NEED THEM

Thank You

Remember – it's your life - we are here to help you

FINANCIAL INFORMATION

Essentially, all agreements for care and finances are between you and us. Insurance carriers may help with the payment. We participate in **Blue Cross Blue Shield, Medicare, Worker's Comp and Auto**. If your insurance carrier is not listed we will be happy to provide you with a receipt for reimbursement of fees paid or to file forms for you if you have out of network benefits.

Payment in full is expected on all first visit services. All other fees (or copays) are to be paid at the time of service unless other arrangements have been made.

Please indicate your method of payment. ❑ cash ❑ check ❑ credit card