

Sideris Family Chiropractic, PC

Dr. Jim Sideris

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Health History

NAME _____ DATE _____

ADDRESS _____ CITY/STATE _____ ZIP _____

OCCUPATION _____ WORK PHONE/S _____

HOME PHONE _____ MOBILE PHONE _____

BIRTHDATE _____ SPOUSE _____ CHILDREN (NAME/AGE) _____

E-MAIL ADDRESS _____

WHO REFERRED YOU TO US? _____

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION _____

LAST VISIT _____

CURRENT MEDICAL CARE? YES/NO WHY? _____

CURRENT DRUGS/MEDICATION _____

REASON FOR CONSULTING THIS OFFICE _____

**PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES
YOUR CURRENT GOALS FOR HEALTH/WELLBEING.**

- I am only concerned about relief of a particular symptom.
- I am only concerned about relief of a particular symptom, and preventing its return.
- I want optimum health and wellbeing on every level available to me.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

**I understand that all services are to be paid in full at the time of service,
unless other arrangements have been made and agreed upon in writing.**

Signature _____ Date _____

PERSONAL HISTORY

THE HUMAN BODY IS DESIGNED TO EXPRESS HEALTH AND FUNCTION NORMALLY. HOWEVER, EVENTS MAY OCCUR IN LIFE, WHICH CAN INTERFERE WITH THIS NATURAL ABILITY.

THIS INTERFERENCE IS MOST COMMONLY THE RESULT OF VERTEBRAL SUBLUXATIONS.

STRESS THAT MAY BE PHYSICAL, CHEMICAL OR EMOTIONAL MAY CAUSE THESE SUBLUXATIONS.

THE PRACTICE OF CHIROPRACTIC IS BASED ON THE LOCATION AND REDUCTION OF NERVE SYSTEM INTERFERENCE CAUSED BY THE VERTEBRAL SUBLUXATION.

(Please circle any that apply)

PLEASE TELL US ABOUT ANY STRESS AT YOUR BIRTH:

- 1) Drugs/medicine/tobacco/alcohol in pregnancy Explain: _____
- 2) Labor chemically induced? _____
- 3) Forceps/Vacuum Extraction/C-section _____
- 4) Premature delivery? _____
- 5) Vaccinations? _____
- 6) Falls in first year of life? _____
- 7) Any health related problems? _____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

- 1) Any falls or injuries? Explain _____
- 2) Allergy/Asthma or Respiratory problems? _____
- 3) Ear infections? _____
- 4) Digestive problems? _____
- 5) Hyperactivity? _____
- 6) Any other health related problems? _____

PLEASE TELL US ABOUT ANY STRESS UP TO PRESENT:

- 1) Auto Injury? Explain _____
- 2) Work Injury? _____
- 3) Sports Injury? _____
- 4) Work Stress? _____
- 5) Family/Home Stress? _____
- 6) Prescription Drug Use? _____
- 7) Non-Prescription Drug Use? _____
- 8) Ever Hospitalized? _____
- 9) Surgery? _____
- 10) Major Illness? _____
- 11) Reoccurring Illnesses? _____
- 12) Limited Exercise? _____
- 13) Poor Nutrition? _____

Anything else? _____

