CEDAR GROVE FAMILY CHIROPRACTIC
Confidential Patient Information

PLEASE PRINT **DATE: _____**

Name: _____

Address: _____City:_____State:_____Zip:_____

Birth Date: _____Age:_____Sex: M☐ F☐ Marital Status: S☐ M☐ W☐ D☐

Cell Phone: _____-_____-_____ Other Phone_____-_____-_____ Occupation_____

Emergency Contact: _____Relation:_____Phone: _____-_____-_____

E-Mail address (for Dr. Jeff's newsletter) _____

Children's Names and Ages: _____

Who may we thank for referring you or how did you hear of us? _____

CURRENT HEALTH CONDITIONS

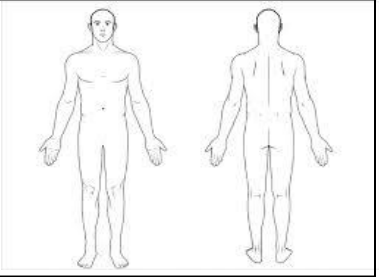
Unwanted Health Concern(s) (please list all):

Have you had same/similar problem(s) before? ❍ Yes ❍No

If so for how long?

List any care you tried to resolve this problem

Please indicate where you are experiencing pain or discomfort
X current O past



When did condition(s) first begin?

How did the problem start?
❍Suddenly ❍Gradually ❍Post-injury
Is this condition:
❍Getting worse ❍Improving ❍Intermittent ❍Constant ❍ Unsure

What makes the problem better?

What makes the problem worse?

YOUR HEALTH GOALS

Your top three health goals

1. _____
2. _____
3. _____

CHIROPRACTIC HISTORY

What would you like to gain from Chiropractic care?

❍Resolve existing condition(s) ❍Overall Wellness ❍Both

Have you ever visited a chiropractor? ❍ Yes ❍No

If yes, what is their name? _____Date of last visit? _____

What is their specialty? ❍Pain relief ❍PT/ Rehab ❍ Subluxation-based ❍Other

Do you have any health concerns for other family members today?

TRAUMA: Physical Injury History

Have you ever had any significant falls, surgeries or other injuries as an adult? ❍Yes ❍No
If yes, please explain:

Notable childhood injuries?

Youth or college sports? ❍Yes ❍No If yes, list major injuries:

Any Auto accidents? ❍Yes ❍No If yes, please explain:

Exercise frequency? ❍None ❍1-2x per week ❍3-5x per week ❍Daily

What type of exercise?

How do you normally sleep? ❍Back ❍Side ❍Stomach
Do you wake up: ❍Refreshed & ready ❍Stiff & tired

Do you commute to work? ❍Yes ❍No If yes, how many minutes per day:

List any problems with flexibility (ex. Putting on shoes/socks, etc.)

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone?

TOXINS: Chemicals & Environmental Exposure Please rate your CONSUMPTION

	None		Moderate		High
Alcohol	❍	❍	❍	❍	❍
Water	❍	❍	❍	❍	❍
Sugar	❍	❍	❍	❍	❍
Dairy	❍	❍	❍	❍	❍
Gluten	❍	❍	❍	❍	❍

	None		Moderate		High
Processed Foods	❍	❍	❍	❍	❍
Artificial Sweeteners	❍	❍	❍	❍	❍
Sugary/Energy Drinks	❍	❍	❍	❍	❍
Cigarettes	❍	❍	❍	❍	❍
Recreational Drugs	❍	❍	❍	❍	❍

Please list any drugs/medications/vitamins/herbs/other that you are taking and why.

1._____ Reason_____ 2._____Reason_____

3._____Reason_____ 4._____Reason_____

THOUGHTS: Emotional Stresses & Challenges Please rate your STRESS for each

	None		Moderate		High
Home	❍	❍	❍	❍	❍
Work	❍	❍	❍	❍	❍
Life	❍	❍	❍	❍	❍

	None		Moderate		High
Money	❍	❍	❍	❍	❍
Health	❍	❍	❍	❍	❍
Family	❍	❍	❍	❍	❍

Patient Signature_____Date_____