WELCOME TO *THE CHIROPRACTIC PLACE*

Please complete all of the following New Patient Information.

NAME:_____DATE:_____

ADDRESS:_____

CITY:_____STATE:_____ ZIP:_____ EMAIL ADDRESS:_____

HOME PHONE:_____WORK PHONE:_____

BIRTH DATE:_____AGE_____ SOCIAL SECURITY#_____

MARITAL STATUS:
____MARRIED ____DIVORCED ____SINGLE ____OTHER

EMPLOYER:_____OCCUPATION:_____

SPOUSES NAME:_____OCCUPATION:_____

CHILDREN'S NAMES AND AGES: _____

WHO MAY WE THANK FOR REFERRING YOU?_____

- **CURRENT HEALTH COMPLAINTS/REASONS FOR CONSULTING THIS OFFICE:**
  1. **_____**
  2. **_____**
  3. **_____**

Have you had similar problems before?_____

If so, for how long?_____

Is this a result of an auto or work accident? Y N Date of accident:_____

Do you have other family members with similar problems? Y N

Other Dr.'s seen for this problem? _____

Previous surgeries:_____

Medications you currently take?_____

Is there a chance you may be pregnant (females only)?_____

Have you ever been diagnosed with cancer? Y N If so, what type?_____

Do have health insurance? Y N Name of company:_____

- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**
- **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the doctor. If account is not paid within 90 days, you will be responsible for legal fees, collection fees and any other costs incurred with collecting your account.**

Signature:_____ Date:_____

Dr. Jason Cerutti
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Hudson, Ohio 44236
www.chiroplaceinc.com

Initial Exam Questionnaire

Patient Name: _____ **Date:** _____

What challenges are you currently experiencing in these areas of life?

Physical Challenges: _____

_____

Health Challenges: _____

_____

Emotional Challenges: _____

_____

Are you having issues with any of the following (check all that apply)?

O Sleeping O Walking O Running O Sitting O Low Energy O Mental/Emotional Stress

On a scale of zero to ten, rate your overall level of HEALTH (0 is poor – 10 is excellent):

O Zero O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

On a scale of zero to ten, rate your current QUALITY OF LIFE (0 is poor – 10 is excellent):

O Zero O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10

Over the past 3 months would you say your health issues are:

O Staying the same O Getting worse O Getting better

Please share any other general health concerns you may be having:

_____

_____

Our goal is to help as many people as possible reach optimal health! Since opening our practice, we have continued to grow through referrals from our wonderful practice members. If you were referred by a patient at *The Chiropractic Place*, please let us know so we can thank them for helping us change lives.

Name: _____

Patient Signature: _____ **Date:** _____

We appreciate the opportunity to serve you!