Cassara Chiropractic Center, LLC, Dr. Ernest Cassara, D.C.
532 Route 70 West, Cherry Hill, NJ 08002 • **P:** 856-857-0018

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you ☺

Name: _____ Today's Date: _____

Address:_____ City / State/ Zip: _____

Phone: Home _____Work: _____ Cell: _____

E-Mail:_____ Marital status: ❑ M ❑ W ❑ D ❑ S

Birth Date: _____ Age: _____ Social Security #: _____

Who may we thank for referring you? _____

Your prior doctor of chiropractic: _____ Last seen: _____

Address: _____ City / State / Zip _____

Chiropractic techniques you've had success with: _____

General practitioner: _____ Phone #: _____

Address: _____ City / State / Zip _____

Your employer: _____ Phone #:_____

Address: _____ City / State / Zip _____

Occupation: _____ Children's names & ages: _____

Spouse's name: _____ Spouse's Occupation: _____

Method of payment for first visit: ❑ Cash ❑ Check ❑ Debit Card ❑ Credit Card

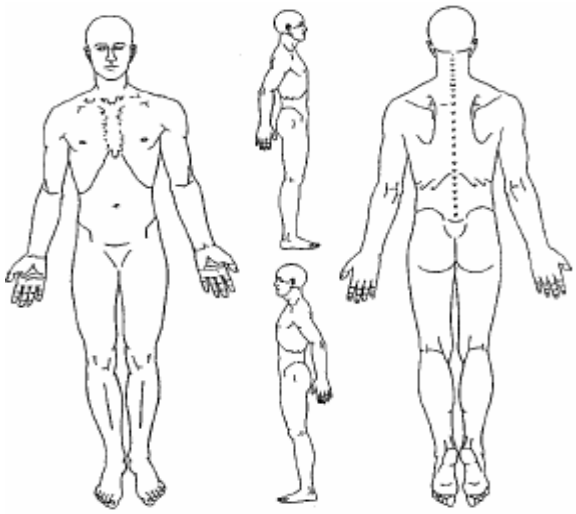
Health Reasons for Consulting Our Office:

1._____

2._____

3._____

Mark area(s) of health concerns



What are you interested in achieving: *Please Check One*

❑ **Relief Care** – Symptomatic relief only

❑ **Corrective Care** – Correcting the cause of the problem in addition to symptomatic relief

❑ **Wellness / Maintenance Care -** Care to prevent reoccurrence of symptoms and achieving optimal health and a healthier lifestyle

❑ **I want the doctor to select the type of care appropriate to my health status**

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Name: _____ Today's Date: _____

Describe **FIRST** main health concern: _____

WHEN did this issue begin? ❑ Unsure _____

HOW did this issue begin? ❑ Unsure _____

Is this a result of a work or auto injury? Yes / No When? _____

Have you ever experienced this before? Yes / No When? _____

Since this issue began, is it ❑ The Same ❑ Better ❑ Getting Worse

Intensity of symptoms: (0=None / 10=Unbearable) 1 2 3 4 5 6 7 8 9 10

How often do you experience symptoms? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Describe symptom: Stiff, Achy, Dull, Sharp, Numb, Tingling, Burning, Weak _____

Increased by: Moving, Lifting, Sitting, Standing, Walking _____

Decreased by: Chiropractic, Heat, Ice, Rest, Stretching, Sleeping, Standing, Sitting, Medications: _____

Does it travel to other areas Y / N (Where to)_____ **Quality**: _____

Onset: ❑ Unsure _____ **Mechanism**: ❑ Unsure_____

Intensity: 1 2 3 4 5 6 7 8 9 10 **Freq** 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

SECOND health concern: _____

WHEN did this issue begin? ❑ Unsure _____

HOW did this issue begin? ❑ Unsure _____

Is this a result of a work or auto injury? Yes / No When? _____

Have you ever experienced this before? Yes / No When? _____

Since this issue began, is it ❑ The Same ❑ Better ❑ Getting Worse

Intensity of symptoms: (0=None / 10=Unbearable) 1 2 3 4 5 6 7 8 9 10

How often do you experience symptoms? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Describe symptom: Stiff, Achy, Dull, Sharp, Numb, Tingling, Burning, Weak _____

Increased by: Moving, Lifting, Sitting, Standing, Walking _____

Decreased by: Chiropractic, Heat, Ice, Rest, Stretching, Sleeping, Standing, Sitting, Medications: _____

Does it travel to other areas Y / N (Where to)_____ **Quality**: _____

Onset: ❑ Unsure _____ **Mechanism**: ❑ Unsure_____

Intensity: 1 2 3 4 5 6 7 8 9 10 **Freq** 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Name: _____ Today's Date: _____

THIRD health concern: _____

WHEN did this issue begin? ❑ Unsure _____

HOW did this issue begin? ❑ Unsure _____

Is this a result of a work or auto injury? Yes / No When? _____

Have you ever experienced this before? Yes / No When? _____

Since this issue began, is it ❑ The Same ❑ Better ❑ Getting Worse

Intensity of symptoms: (0=None / 10=Unbearable) 1 2 3 4 5 6 7 8 9 10

How often do you experience symptoms? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Describe symptom: Stiff, Achy, Dull, Sharp, Numb, Tingling, Burning, Weak _____

Increased by: Moving, Lifting, Sitting, Standing, Walking _____

Decreased by: Chiropractic, Heat, Ice, Rest, Stretching, Sleeping, Standing, Sitting, Medications: _____

Does it travel to other areas Y / N (Where to)_____ **Quality**: _____

Onset: ❑ Unsure _____ **Mechanism**: ❑ Unsure_____

Intensity: 1 2 3 4 5 6 7 8 9 10 **Freq** 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

FOURTH health concern: _____

WHEN did this issue begin? ❑ Unsure _____

HOW did this issue begin? ❑ Unsure _____

Is this a result of a work or auto injury? Yes / No When? _____

Have you ever experienced this before? Yes / No When? _____

Since this issue began, is it ❑ The Same ❑ Better ❑ Getting Worse

Intensity of symptoms: (0=None / 10=Unbearable) 1 2 3 4 5 6 7 8 9 10

How often do you experience symptoms? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Describe symptom: Stiff, Achy, Dull, Sharp, Numb, Tingling, Burning, Weak _____

Increased by: Moving, Lifting, Sitting, Standing, Walking _____

Decreased by: Chiropractic, Heat, Ice, Rest, Stretching, Sleeping, Standing, Sitting, Medications: _____

Does it travel to other areas Y / N (Where to)_____ **Quality**: _____

Onset: ❑ Unsure _____ **Mechanism**: ❑ Unsure_____

Intensity: 1 2 3 4 5 6 7 8 9 10 **Freq** 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

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Most of your current symptoms are an accumulation of stress that builds up over many years. Include anything that has occurred <u>from childhood through today</u>. Please answer the following questions completely to give us better insight into your current health concerns.

****Please mark N/A if it does not apply****

Have you seen a doctor for these concerns? Yes / No ❑ Chiropractor ❑ MD ❑ Other:

Doctor: _____ Date: _____ Diagnosis: _____

Prior treatments: _____ ❑ N/A

Tests done, locations with dates: _____ ❑ N/A

Past auto accidents *(5 mph and above?)* with dates: _____ ❑ N/A

Sports: _____ ❑ N/A

Broken bones: _____ ❑ N/A

Surgeries with dates: _____ ❑ N/A

Slip/Fall with dates: _____ ❑ N/A

Serious illnesses/Past medical history: _____ ❑ N/A

Hobbies: _____ ❑ N/A

Work environment and physical positioning: _____ ❑ N/A

Medication (s) you are currently taking: _____ ❑ N/A

Have you ever been diagnosed with cancer? ❑ Yes ❑ No

If so, what kind? _____

What have you heard about chiropractic? _____

_____

Do you know what a vertebral subluxations complex is? If yes, please describe _____

_____

What daily rituals for spinal health do you presently practice? _____

_____

Do you have health insurance? ❑ No ❑ Yes Name of company: _____

Are you the ❑ Insured ❑ Spouse or ❑ Dependent?

If you are not the insured, Please list their Name: _____ D.O.B _____

The above information is true and accurate to the best of my knowledge. The reason for my consultation with the Doctor is for an evaluation of my physical health and potential for improvement.

Patient or Guardian Signature: _____ **Date:** _____