Dr. John Thomas Cece
Chiropractic Physician

Chiropractic
Physical Medicine
Sports Medicine

Full Name: _____ Email Address: _____ Date: _____
Social Security #:_____ Date of Birth: _____ Age: ____ ☐ Male ☐ Female
Spouse/Significant Other: _____ Date of Birth: _____
Home Address: _____ City: _____ State: ___ Zip: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
** Please indicate preferred phone #: ☐Home ☐Work ☐Cell*
Employer: _____ Employer Address: _____
City: _____ State: ____ Zip: _____
Emergency Name & Number: _____
How did you hear about the doctor? Who can we thank for referring you to our office?
_____
If you are seeing the doctor as a result of an auto accident, please provide:
Insurance Company Name: _____ Contact: _____
Phone #: _____ Claim #: _____

YOUR HEALTH PROFILE

What is your primary reason for seeking chiropractic care at this time? _____
_____
Have you ever had the same issue(s) before? ☐ No ☐ Yes (explain)_____
What other providers have you seen for these complaints? _____
_____
When/how did your symptoms begin? _____
_____
Are there any major injuries/surgeries we should know about? _____
_____
My current symptoms interfere with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure
What is the <u>most</u> important aspect of life that your current pain prevents you from doing/enjoying?
_____
_____
Have you ever seen a chiropractor before? _____
What are your overall health and wellness goals? _____
_____
Do you play any sports? _____
How would you describe your overall health? _____
In my daily activities/work I *(check one):* ☐ Sit more than stand ☐ Stand more than sit
☐ Sit/Stand equally ☐ Walk frequently

71 Franklin Turnpike, Suite 5
Waldwick, NJ 07463
Phone: 201-445-9739 Fax: 201-445-9401

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HEALTH CONCERNS/HISTORY

**Please check all that apply:*

☐ Anxiety/Depression
☐ Dizziness/Fainting
☐ Diabetes
☐ Loss of Concentration
☐ Loss of Balance
☐ Stiffness/Flexibility
☐ Irritability
☐ Pins & Needles in arm/legs
☐ Menstrual Irritability
☐ Loss of Smell
☐ HIV/AIDS
☐ Cancer/Tumor
☐ Epilepsy/Seizures
☐ History of Neck Pain
☐ Aortic Aneurysm
☐ Wear orthotics
☐ Other _____

☐ Fatigue/Sleep Issues
☐ Nausea/Vomiting
☐ Sensitivity to Light
☐ Arthritis
☐ Headaches
☐ Pain in Arms/Legs
☐ Cold Hands/Feet
☐ Ulcers or Heartburn
☐ Menstrual Pain
☐ Loss of Taste
☐ Osteoporosis
☐ Recent Trauma
☐ Visual Disturbances
☐ Urinary Retention
☐ Prostate Problems
☐ Broken bones *(explain):* _____

☐ Digestive Issues/Diarrhea/Constipation
☐ Ringing In Ears
☐ Hypertension
☐ Memory Problems
☐ Neck/Back Pain
☐ Sinus Troubles/Allergies
☐ Numbness in fingers/toes
☐ Hot Flashes or Cold Sweats
☐ Mood Swings
☐ Recent Infection or Fever
☐ Numbness in Groin/Buttocks
☐ Abnormal Weight – gain or loss
☐ History of Low/Mid Back Pain
☐ Frequent Urination
☐ Pregnancy, # of births _____

Explain any boxes checked above or add additional concerns:

_____
_____
_____

Is there anything else regarding your current condition you feel the doctor should know?

_____
_____
_____

MEDICATIONS

☐ Anxiety/Depression ☐ ADD/ADHD
☐ Cholesterol ☐ Diabetes
☐ Blood Pressure ☐ Pain Narcotics
☐ Migraine/Headache ☐ Muscle Relaxers
☐ Corticosteroid Use (Steroid Inhaler)
☐ Birth Control Pills
☐ Other: _____

Explain boxes checked above:

_____
_____

VITAMINS/SUPPLEMENTS

☐ Multi-Vitamin
☐ Vitamin D3
☐ Fish Oil/Omega-3
☐ Probiotics
☐ _____ ☐ _____
☐ _____ ☐ _____

Explain boxes checked above:

_____
_____
_____

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Health Status Questionnaire

Your Physical Life

Rate based on a frequency scale of 1 – 5 (1=Never, 2=Rarely, 3=Occasionally, 4=Regularly, 5=Constantly)

Presence of physical pain	1 2 3 4 5	Incidence of colds or flu	1 2 3 4 5
Feelings of tension, stiffness, lack of flexibility	1 2 3 4 5	Ability to work out or engage in activity	1 2 3 4 5
Incidence of fatigue or low energy	1 2 3 4 5	Incidence of chronic disease	1 2 3 4 5

Your Mental/Emotional State

Rate based on a frequency scale of 1 – 5 (1=Never, 2=Rarely, 3=Occasionally, 4=Regularly, 5=Constantly)

Presence of negative feelings/energy	1 2 3 4 5	Being overly worried about small things	1 2 3 4 5
Moodiness, temper, or angry outbursts	1 2 3 4 5	Difficulty thinking or concentrating	1 2 3 4 5
Difficulty falling or staying asleep	1 2 3 4 5	Feeling of depression or anxiety	1 2 3 4 5

Your Chemical/Nutritional Life

Rate based on a frequency scale of 1 – 5 (1=Never, 2=Rarely, 3=Occasionally, 4=Regularly, 5=Constantly)

Eat a well-balanced diet	1 2 3 4 5	Eat an organic/hormone-free diet	1 2 3 4 5
Eat a diet rich in fruits & vegetables	1 2 3 4 5	Use a lot of chemicals on your skin	1 2 3 4 5
East fast food or highly processed food	1 2 3 4 5	Ingestion of chemicals	1 2 3 4 5
Drink water daily (___ glasses/day)	1 2 3 4 5	Daily alcohol intake	1 2 3 4 5
Daily caffeine intake	1 2 3 4 5	Daily tobacco use	1 2 3 4 5

Stress Evaluation

Rate based on a frequency scale of 1 – 5 (1=Never, 2=Rarely, 3=Occasionally, 4=Regularly, 5=Constantly)

Family	1 2 3 4 5	Work/School	1 2 3 4 5
Significant relationship	1 2 3 4 5	Day-to-day	1 2 3 4 5
Health	1 2 3 4 5	Finances	1 2 3 4 5

Life Enjoyment

Rate based on a frequency scale of 1 – 5 (1=Never, 2=Rarely, 3=Occasionally, 4=Regularly, 5=Constantly)

Experience of relaxation, ease or well-being	1 2 3 4 5	Feelings of compassion and acceptance	1 2 3 4 5
Interest in maintaining a healthy lifestyle/diet	1 2 3 4 5	Level of recreation in your life	1 2 3 4 5
Time devoted to things you enjoy	1 2 3 4 5	Interest in your physical appearance	1 2 3 4 5

What else about your health do you feel is important for the doctor to know?

_____

_____

_____

_____

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