SPINAL CORRECTIVE CENTER, P.C.
Chiropractic for Pediatric Development & Adult Health

Dr. W. Gene Cretsinger gcretsinger@spinalcc.com
Dr. Janet M. Cuhel jcuhel@spinalcc.com
3800 River Ridge Dr. NE Cedar Rapids, IA 52402
(319) 393-3996 www.spinalcc.com

Patient Information

SSN: _____ Birthday: _____

*First Name: _____ Middle Name: _____ *Last Name: _____

Sex: ◯M ◯F Height: _____ Weight: _____

Married/Civil Union: ◯Married ◯Single Spouse Name: _____ # of Children: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

*Email: _____

Employer Information

Employed: ____Full Time ____Part Time ____Homemaker ____Unemployed ____Employer Name _____

Occupation: _____

Physical Work Duties: _____

History

If multiple nutrition supplements/medications, please bring list

List current vitamins, minerals, supplements, or herbs: _____
(name, amounts, frequency, length of use, reason for use)

List current Medications: _____
(name, amounts, frequency, length of use, reason for use)

Health Checklist

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ High Blood Pressure	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ Spinal Curvatures	☐ Sinus Infection	☐ Insomnia
☐ Swollen Joints	☐ Stroke	☐ Swelling of Ankles
☐ Ulcers	☐ Thyroid Condition	☐ Tuberculosis
	☐ Varicose Veins	☐ Venereal Disease

☐ Other: _____

Social History & Life Choices

Alcohol:	◯Daily	◯Weekly	◯Occasionally	◯Never	Caffeine Drinks	◯Daily	◯Weekly	◯Occasionally	◯Never
Diet Food Products:	◯Daily	◯Weekly	◯Occasionally	◯Never	Drugs:	◯Daily	◯Weekly	◯Occasionally	◯Never
OTC Stimulants:	◯Daily	◯Weekly	◯Occasionally	◯Never	Exercise:	◯Daily	◯Weekly	◯Occasionally	◯Never
Homemade Food:	◯Daily	◯Weekly	◯Occasionally	◯Never	Processed Food:	◯Daily	◯Weekly	◯Occasionally	◯Never
Soft Drinks:	◯Daily	◯Weekly	◯Occasionally	◯Never	Tobacco:	◯Daily	◯Weekly	◯Occasionally	◯Never
Water:	◯Daily	◯Weekly	◯Occasionally	◯Never					

Chiropractic Experience

Who referred you to our office? _____

How did you find our office? ☐ Referred By Friend ☐ Website ☐ Social Media ☐ Health Care Provider

Have you been adjusted by a chiropractor before? ◯Yes ◯No

If yes, what was the reason ? _____

Doctor's Name: _____ Date of last visit _____

Has any member of your family ever seen a wellness chiropractor? ◯Yes ◯No

Reason for this Visit

Describe the reason for this visit: _____

_____

_____

_____

When did this concern begin? _____

Has this concern? ◯Gotten Worse ◯Stayed Constant ◯Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ◯Yes ◯No Briefly Explain: _____

Have you seen other Doctors/Therapists for this concern? ◯Yes ◯No Doctor's/Therapists Name: _____

Type of Treatment: _____

Results: ◯Good ◯Bad ◯Indifferent