CHIROPRACTIC
STRATEGIES GROUP
MOVE WELL · LIVE FULLY

Chiropractic Strategies Group, Inc.
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New Patient Information Form

Please complete this form before your first visit. Do not use this form for emergencies.

PATIENT INFORMATION

FULL LEGAL NAME _____ **PREFERRED NAME** _____

DATE OF BIRTH _____ **PRONOUNS** _____ **MARITAL STATUS** _____

STREET ADDRESS _____ **CITY, STATE, ZIP** _____

PHONE _____ **EMAIL** _____

EMERGENCY CONTACT AND RELATIONSHIP _____ **EMERGENCY CONTACT PHONE** _____

REASON FOR VISIT

PRIMARY CONCERN

_____

WHEN DID IT BEGIN? _____ **HOW DID IT BEGIN?** _____

Areas of concern:

- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ Shoulder
- ☐ Hip
- ☐ Other

How does it affect daily activities?

_____

What would you most like to improve?

_____

HEALTH HISTORY

Previous injuries, surgeries, hospitalizations, or significant conditions:

_____

Current medications and supplements:

_____

Known allergies: _____

Previous chiropractic, physical therapy, or related care:

ACKNOWLEDGMENT

I certify that the information provided is accurate to the best of my knowledge. I understand that completing this form does not confirm an appointment or establish a provider-patient relationship.

PATIENT OR GUARDIAN SIGNATURE _____ **DATE** _____