Eagle Chiropractic @ Glenmoore PATIENT HISTORY

Date of Birth _____ Email _____
Last Name _____ First Name _____ MI_____
Address _____ Apt # _____
City _____ State _____ Zip _____
Phone (H) _____(W) _____ (Cell) _____
Spouse's Name _____ Spouse Date of Birth _____
Your Occupation _____ Employer _____
Primary Physician's name _____ PCP Phone _____
Insurance Company _____
Have you ever been to another doctor for this problem? Y N Who? _____
Who referred you to this office? _____ Do you smoke? Yes No
Ethnicity: _____ Phone Communication Preference: Cell Home Work

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____100% _____75% _____50% _____25% _____10%
- PAIN INTENSITY: Please put an "X" on the line below describing the intensity of your pain.

No Pain ----------Unbearable Pain

OTHER COMPLAINT: _____

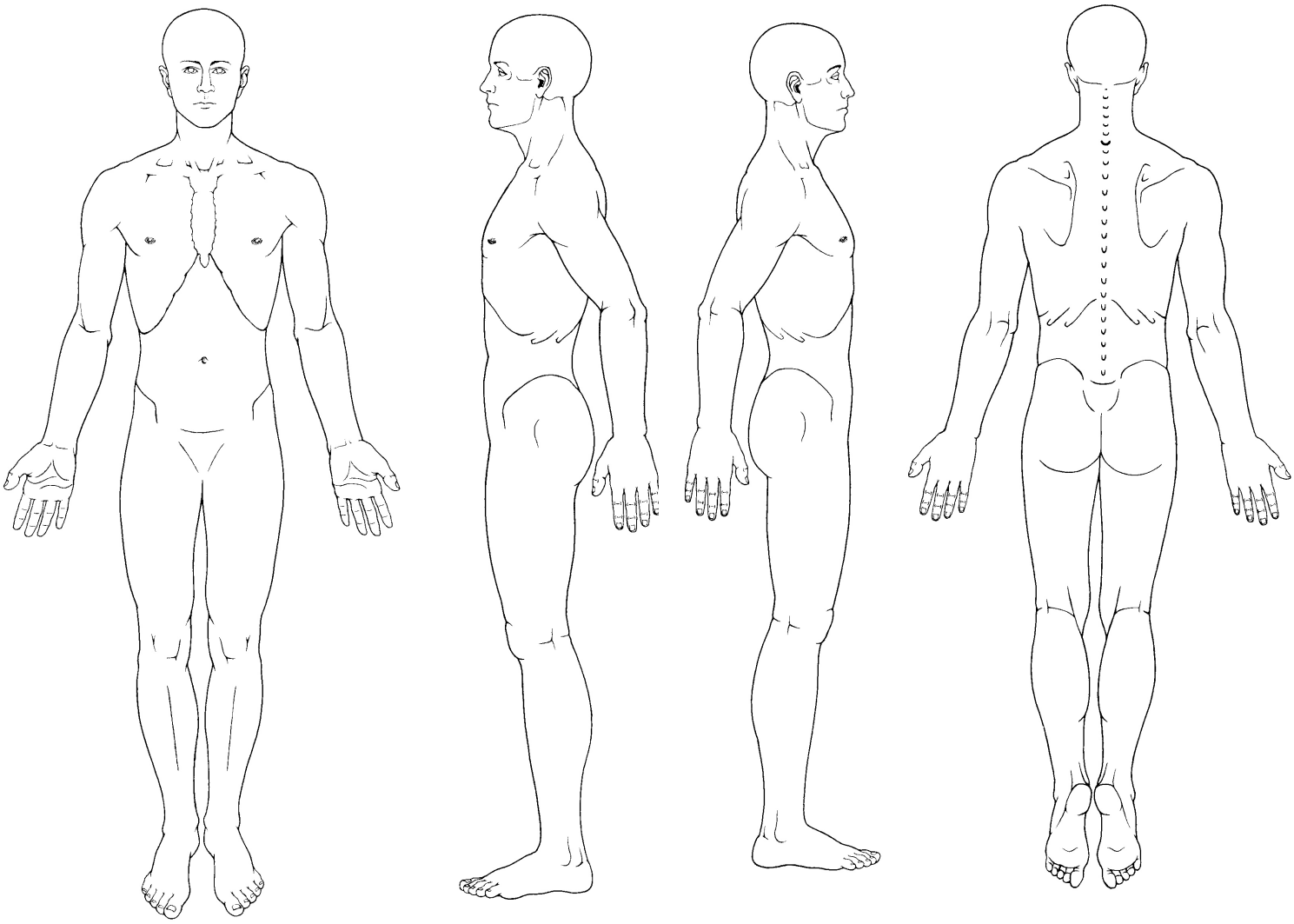
- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____Ache _____ Burn _____Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____Y _____N
- How often do you experience these symptoms?
  _____100% _____75% _____50% _____25% _____10%
- PAIN INTENSITY: Please put an "X" on the line below describing the intensity of your pain.

No Pain----------Unbearable Pain

PATIENT SIGNATURE _____DATE _____

Eagle Chiropractic @ Glenmoore **PATIENT HISTORY**

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

PATIENT SIGNATURE _____ DATE _____

Eagle Chiropractic @ Glenmoore PATIENT HISTORY

Please list previous major health conditions, diagnosis, or issues: *(example: Cancer, High BP, Asthma, etc...)*

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list all past surgeries:

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____

Please list all previous accidents and falls:

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

List any medications or vitamins you are taking: (including frequency and dose if possible)

_____
_____
_____

List any allergies to medications:_____

Please read carefully and sign below

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Signature:_____ Date:_____

Consent to Treat a Minor:
I, the undersigned do hereby give my consent to Eagle Chiropractic and its representatives to examine and treat _____. I also swear that this minor is under my legal guardianship.
Guardian Signature _____ Date _____

PATIENT SIGNATURE _____DATE _____