Eagle Chiropractic

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Office@eaglechiropractic.net

Name: _____ Birthdate: _____

Address:_____

_____

Phone Numbers: Home_____ Cell_____

Email address: _____

Social Security Number: _____ Gender: _____

Race / Ethnicity:_____ Smoking Status:_____

Marital Status:_____ Spouse's Name_____

Children's names and ages_____

Your occupation:_____ Your employer:_____

Location of your work: _____

Who is your Primary Care Physician? _____

Who may we thank for referring you to our office? _____

Have you consulted a Chiropractor before? Yes / No

The symptoms you seek care for include:_____

_____

And they are the result of: Work, Auto Accident, Unspecified, Other_____

Onset: When did you first notice these symptoms?_____

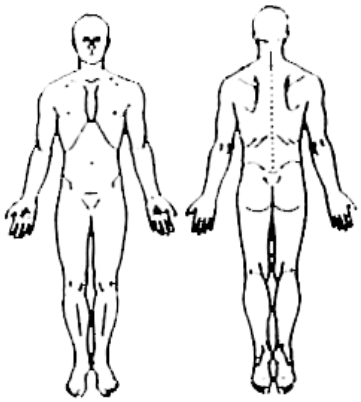
Intensity: How extreme are your symptoms? 0-absent 10-agonizing _____

Duration and Timing: When did this start and how often do you feel it? _____

_____

Quality of the Symptoms: What does it feel like? _____
(Potential answers: Numbness, Tingling, Stiffness, Dull, Aching, Cramping, Sharp, Shooting, Burning, Throbbing, Stabbing)

Location: Please mark areas of pain on the figure to the right: →



Radiation: Does the pain spread or radiate to any other part of your body? If so, where? _____

Aggravating or relieving factors: What makes it better or worse, such as time of day, movements, or other activities?

Pain increases with: _____

Pain decreases with:_____

Prior Interventions (What have you done to relieve the symptoms?)_____

_____

(Potential answers: Prescription Medication, Over the Counter drugs, Homeopathic Remedies, Physical Therapy, Surgery, Acupuncture, Chiropractic, Massage, Ice, Heat)

Is there anything else you would like the doctor to know about your condition?

_____

_____

How does your current condition interfere with your:

Work or career: _____

Recreational activities:_____

Household responsibilities:_____

Personal relationships:_____

Review of other Systems

Chiropractic care focuses on your nervous system, which controls and regulates your entire body. Please indicate any conditions you have Had or currently Have. Put an x for Had and fill in the circle for Have

Musculoskeletal:

- None of the below
- Osteoporosis
- Knee Injuries
- Arthritis
- Foot / ankle pain
- Scoliosis
- Shoulder problems
- Neck pain
- Elbow / wrist pain
- Back problems
- TMJ issues
- Hip disorders
- Poor posture

Neurological problems

- None of the below
- Anxiety
- Depression
- Headache
- Dizziness
- Pins and needles
- Numbness

Cardiovascular problems

- None of the below
- High blood pressure
- Low blood pressure
- High cholesterol
- Poor circulation
- Angina
- Excessive bruising

Respiratory problems

- None of the below
- Allergies
- Asthma
- Apnea
- Emphysema
- Hay fever
- Shortness of breath
- Pneumonia

Digestive

- None of the below
- Anorexia / Bulimia
- Ulcer
- Food sensitivities
- Heartburn
- Constipation
- Diarrhea

Sensory

- None of the below
- Blurred vision
- Ringing in ears
- Hearing loss
- Chronic ear infection
- Loss of smell
- Loss of taste

Skin

- None of the below
- Skin cancer
- Psoriasis
- Eczema
- Acne
- Hair loss
- Rash

Does your condition currently interfere with your life and ability to function? Please note any activities that are hindered due to your condition:

- Sitting
- Standing
- Walking
- Lying down
- Bending over
- Climbing
- Exercising
- Turning your head
- Sleeping
- Other: _____

Please list any medications you take, the dosages, frequencies:

_____

_____

Do you have any medication allergies? _____

What is the major stressor in your life? _____

How many hours of sleep do you average per night? _____

How long have you had your current mattress? _____

In what position do you usually sleep? _____

What is the most significant thing you could do to improve your health? _____

_____

In addition to the main reason for your visit today, what are some other health goals you have? _____

Additional comments: _____

_____

Please sign below:

I hereby request and authorize Dr. Andrew Gottlieb and Dr. Cynthia Glendening and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic care as he/she deems necessary to me or my dependent minor child. I also acknowledge HIPPA privacy protection practices and policies.

 Regular Fees with Insurance: If you decide to use health insurance that covers Chiropractic, you will be charged our regular fees. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. Collection fees will apply to all delinquent account balances processed through our collection agency.

 No Show Fee: If you do not show up for your appointment, a $15 fee will be charged to your account. We appreciate a 24-hour notice for cancellations and a 4 hour notice for rescheduling.

Print Name: _____

Signature_____

Today's Date _____

If here with your child:

Your Relationship to the Child: _____

Child's Name: _____