

EAGLE CHIROPRACTIC, P.C.

PATIENT HISTORY

Date of Birth _____	Social Security Number _____ - _____ - _____
Last Name _____	First Name _____ MI _____
Address _____	Apt # _____
City _____	State _____ Zip _____ E-Mail _____
Phone (H) _____	(W) _____ (Cell) _____
Spouse's Name _____	Social Security Number _____ - _____ - _____ DOB _____
Your Occupation _____	Employer _____
Employer Address _____	
Insurance Company _____	Policy Number _____
Have you ever been to another doctor for this problem? Y N	Who? _____
Who referred you to this office? _____	

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: _____

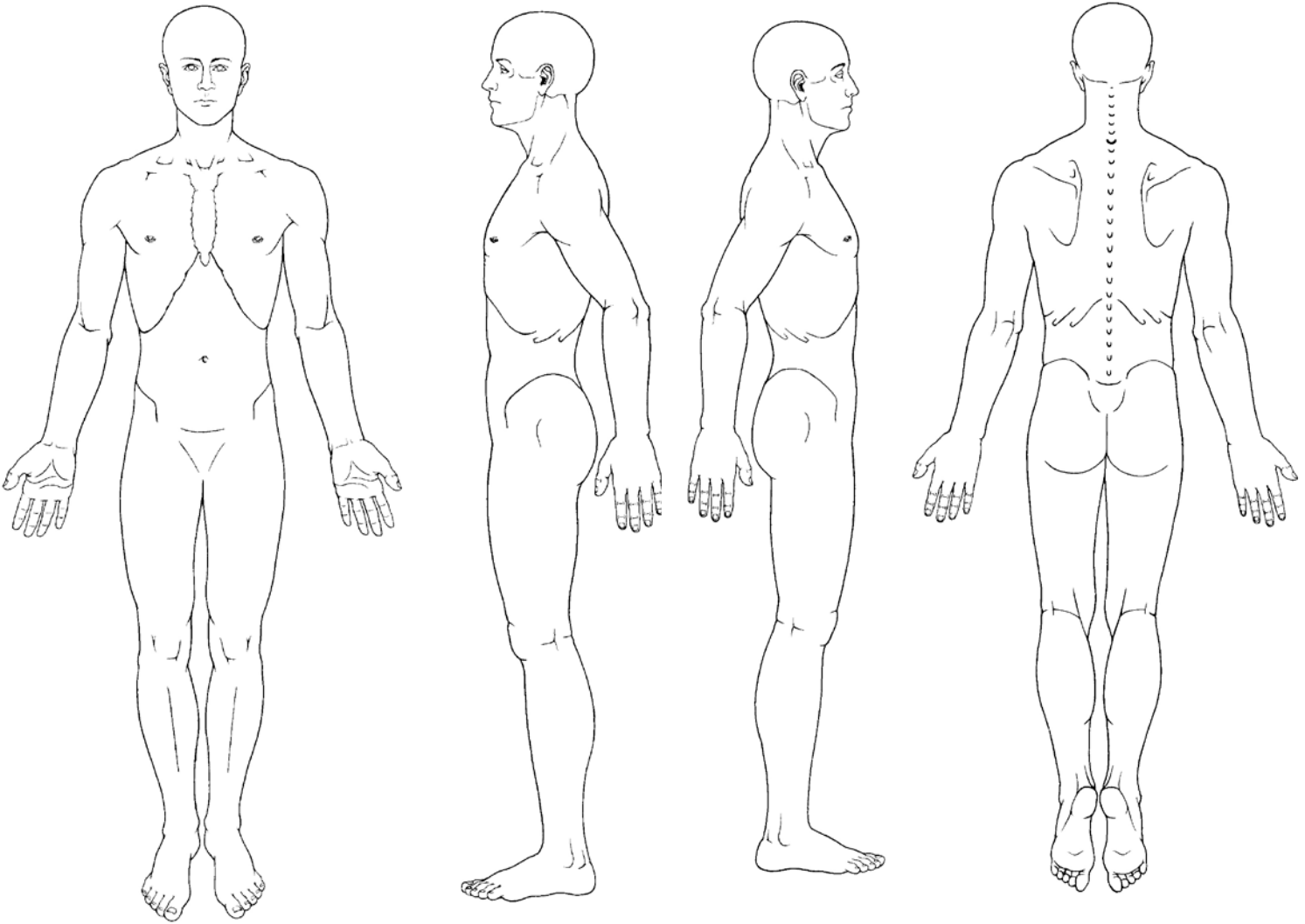
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PATIENT SIGNATURE _____ DATE _____

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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**

PATIENT SIGNATURE _____ DATE _____

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CCC Where you experience Cramping

Please list all previous treatments for this condition:

Name of Treating Physician _____ Dates of Treatment _____
Type of Treatment or Drugs Prescribed _____

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Type of Treatment or Drugs Prescribed _____

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 _____

Please list any medications or vitamins you are currently taking:

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 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 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.

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 _____