Case # _____ Today's Date: _____

Eagle Chiropractic Clinic

Confidential Case History

Please Print

Name: _____
(Last) (First) (Middle Initial)

Nickname: _____ **Sex:** M F

Birth Date: _____ **SSN:** _____

Home Address: _____
(Street Address) (City) (State) (Zip)

Phone: (Home) _____ (Cell) _____ (Work) _____

Cell Phone Service (for texting): AT&T Metro PCS Sprint T-Mobile Verizon Other_____

Email: (work)_____(home)_____

Insurance Provider (Please present card): _____

Employer: _____ **Occupation:** _____

Employer's Address: _____

Contact Preference (please circle one):

Phone: Home Work Cell Text

Email: Home Work

Marital Status: Single Married Divorce Widow

Spouse's Name: _____

Spouse's (or responsible party's) Birth date:_____ **SSN:** _____

Spouse's Employer: _____ **Occupation:** _____

Spouse's Work Address: _____

Emergency Contact: Name: _____

Relationship: _____ Contact #: _____

Language (please circle all that apply):

English Spanish Indian Japanese Chinese Korean French
German Russian Other_____

Race (please circle):

White / Caucasian Black / African American American Indian Pacific Islander Asian
Alaskan Native Hawaiian Native Hispanic / Latino Decline to Answer

Ethnicity (please circle):

Hispanic / Latino Not Hispanic / Latino Decline to Answer

Referred By: _____

Past Chiropractic Care: Yes No When: _____ **Chiropractor:** _____

Results from Care: _____

Reason for today's visit: _____

_____

Is your present condition due to an injury? Yes / NO At Work Auto Accident Personal Other

If yes, have you made a report of your accident? Police Auto Carrier Work Comp Other

If so, have you retained an attorney? _____
(Attorney Name) (Phone Number)

Case # _____ Today's Date: _____

Are you seeing anyone else for other problems or health conditions? Yes No
Doctor or facility: _____

Circle: **High Blood Pressure** **Heart Condition** **Diabetes** **Cancer** _____
Other _____

List dates of accidents or falls? **Auto** _____ **School** _____
Work _____ **Sports** _____ **Other** _____

Medication: **NONE**
Please list any medications you are currently taking to include vitamins, herbs, and minerals. Describe start dates, brand name and / or generic name, strength, dosage, frequency, duration, quantity, refills, and provider. _____

_____

Do you have allergies? Food Environmental Medication None
Please list allergy and reaction: _____

_____

Have you…			**If yes, please provide dates, providers, and reason/cause.**
…been hospitalized in the last 5 years?	Yes	No	_____
…been disabled?	Yes	No	_____
…been out of the country?	Yes	No	_____
…had any broken bones?	Yes	No	_____
…been on crutches?	Yes	No	_____
…had spinal taps or injections?	Yes	No	_____
…been knocked unconscious?	Yes	No	_____
…had x-rays taken?	Yes	No	_____
…been diagnosed with Diabetes?	Yes	No	_____
Type I _____ Type II _____			

Please indicate your participation in the following:

Smoke:	Never	Former (Smoke-free since _____)	Yes (_____ packs per day / week)
Alcohol:	Never	Former (Alcohol-free since _____)	Yes (_____ drinks per day / week)
Caffeine:	Never	Former (Caffeine-free since _____)	Yes (_____ drinks per day / week)
Exercise:	Never	Daily Weekly	Activity: _____

What do you do for recreation? _____

Are you up to date on current vaccinations: YES / NO

List dates of operations or procedures:

Tonsillectomy _____	Tubes in Ears _____	Sinus _____	Hernia _____
Appendectomy _____	Thyroid _____	Stomach _____	Gall Bladder _____
Female Organs _____	Back Surgery _____	Rectal _____	Other _____
Breast:	Augmentation _____	Reduction _____	Other _____

List dates of most recent exams:

Spinal _____	Physical _____	Lab Work _____	MRI _____
PAP Smear _____	Breast Exam _____		

Family History: Please specify parent, grandparent, aunt, and/or uncle for specified conditions.
Diabetes _____ Heart Disease _____ Kidney Disease _____ Cancer _____ Other _____

Have you had any of the following (circle all that apply)?

Appendicitis	Anemia	Heart Disease	Arthritis	Epilepsy	Eczema	Goiter
Pneumonia	Measles	Influenza	Chicken Pox	Polio	Mumps	AIDS
Diabetes	Cancer	Pleurisy	Tuberculosis	Alcoholism	Mental Disorder	
Whooping Cough		Rheumatic Fever		Venereal Infection		

Case # _____ Today's Date: _____

For the following sections, please write a "2" for previous condition or "3" for present condition. Leave blank if never.

General Symptoms:
___Headache
___Fever
___Chills
___Night Sweats
___Fainting
___Dizziness
___Convulsions
___Loss of Sleep
___Fatigue
___Nervousness
___Weight Loss
___Numbness or Pain in Arms/Legs/Hands/Feet
___Wheezing
___ Neuralgia

Gastro-Intestinal:
___Poor Appetite
___Poor Digestion
___Excessive Hunger
___Belching or Gas
___Nausea
___Vomiting
___Vomiting Blood
___Pain over Stomach
___Constipation
___Diarrhea
___Heartburn
___Colon Trouble
___Hemorrhoids
___Liver Trouble
___Jaundice
___Gall Bladder Trouble

Eye/Ear/Nose/Throat:
___Poor Vision
___Crossed Eyes
___Pain in the Eyes
___Deafness
___Earache
___Ear Noises
___Ear Discharge
___Nasal Obstruction
___Nose Bleeds
___Sore Throats
___Hoarseness
___Hay Fever
___Asthma
___Frequent Colds
___Thyroid Trouble
___Tonsillitis
___Sinus Trouble

Respiratory:
___Chronic Cough
___Spitting Blood
___Spitting Phlegm
___Chest Pain
___Difficulty Breathing

Genito-Urinary
___Frequent Urination
___Painful Urination
___Blood in Urine
___Kidney Infection
___Bed Wetting
___Inability to Control Urine
___Prostate Trouble

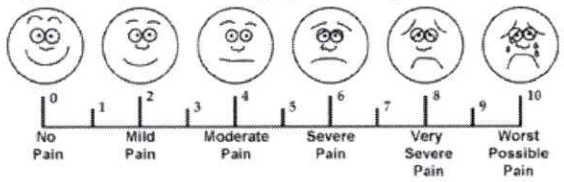
Muscle & Joints:
___Weakness
___Twitching
___Stiff Neck
___Back Ache
___Swollen Joints
___Tremors
___Foot Trouble
___Hernia
___Numbness or Tingling

Cardio-Vascular:
___Rapid Heart Beat
___Slow Heart Beat
___High Blood Pressure
___Low Blood Pressure
___Pain Over Heart
___Previous Heart Trouble
___Swollen Ankles
___Poor Circulation
___Varicose Veins
___Stroke

Skin or Allergies:
___Skin Eruptions
___Itching
___Bruises easily
___Dryness / Scaling
___Sensitive Skin
___Hives or Rash
___Eczema

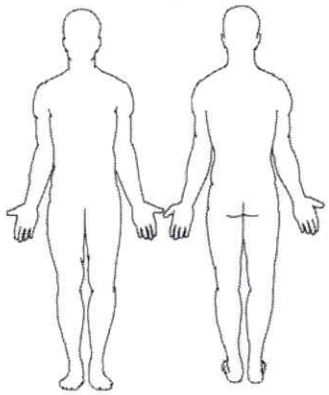
For Women Only
___Painful Periods
___Excessive Flow
___Irregular Cycle
___Hot Flashes
___Painful Cramps
___Miscarriage
___Vaginal Discharge
___Pregnant

List body part in pain and assign pain rating number from scale.



	Body Part	Pain Rating Number
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Mark specific body parts with type of pain.



Type of Pain Symbols
0000 Sharp (Stabbing)
Aching
------ Throbbing
/////// Pins and Needles
++++ Burning
<<<< Numbness

By signing this form, I am stating that the above information is correct to the best of my knowledge. I am also signing as indication of my understanding of the financial arrangement made between Eagle Chiropractic Clinic and me. It is my understanding that all charges incurred in this office are my responsibility, and should my insurance company, for any reason, fail to pay any of the services billed, I will pay for such services immediately upon notification from this office. I am responsible for any collections fees in the event that they are incurred on my case profile. I also agree that if I am unable to make a payment at the time of service, I will notify the office in advance at which time my appointment will be canceled and rescheduled for a time in which I can meet my financial obligations. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I agree it is soley my responsibility to notify this office of any changes of my contact information including change of address and telephone number, as well as any changes to my insurance coverage.

I hereby authorize the doctor to examine and treat my condition as he / she deems appropriate through the use of chiropractic health care, and I give authority for those procedures to be performed. It is understood and agreed the amount paid the doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. The doctor will not be held responsible for pre-existing medically diagnosed conditions, nor for any medical diagnosis.

_____ _____
(Patient Signature) (Date)