

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? _____
 Would you like to receive our monthly office newsletter to keep you informed about the latest health information, changes in office hours, and monthly health workshops offered in the office? Y N

WHAT BRINGS YOU TO OUR OFFICE?

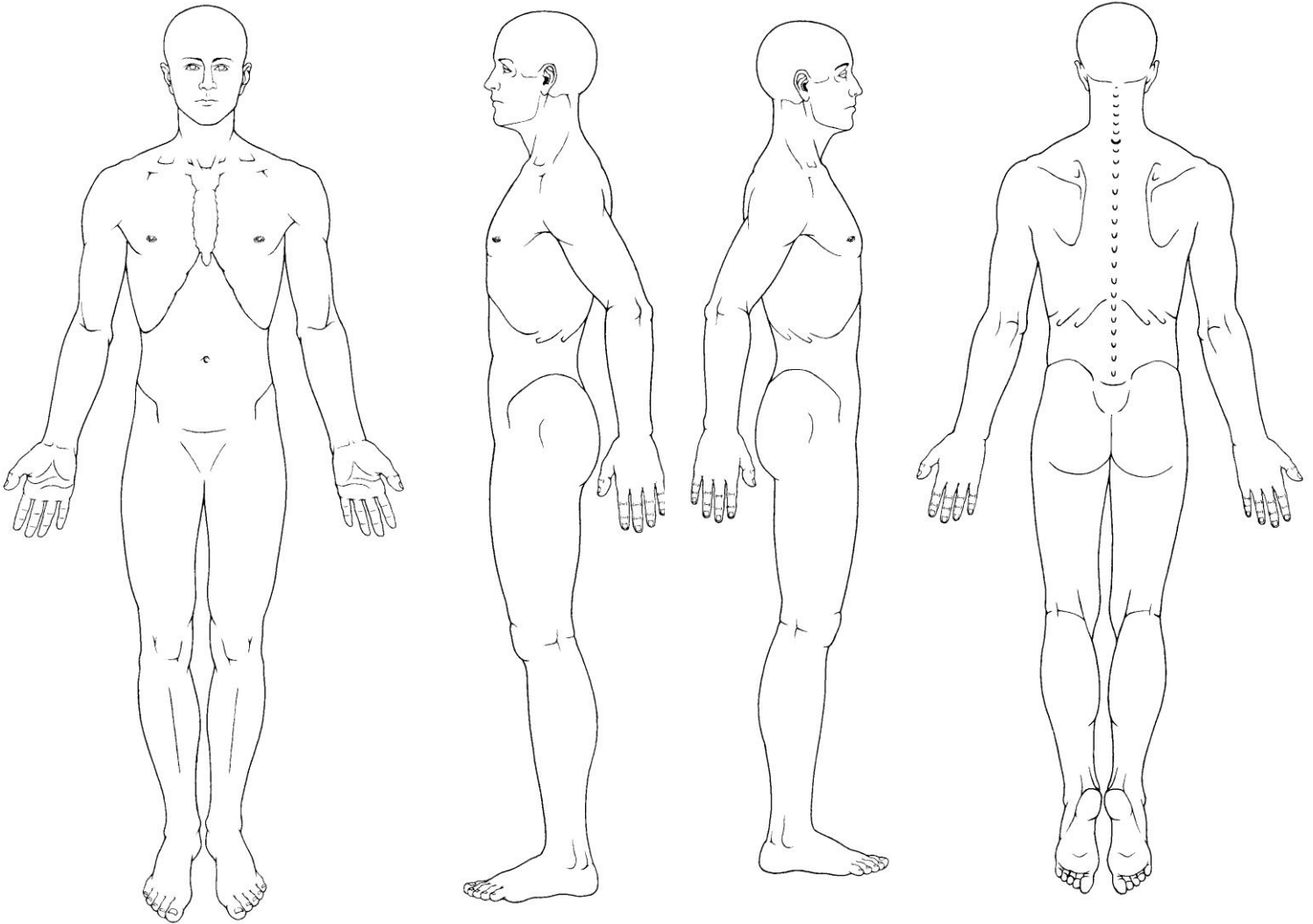
FIRST COMPLAINT: _____

- 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

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 _____

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 _____

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 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.

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 _____