

# Eaton Chiropractic Center

## Confidential Patient Information

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M or F Marital Status: \_\_\_\_\_ # of Children: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

\_\_\_\_\_  
Occupation Employer City Work Phone

\_\_\_\_\_  
Spouse or Guardian Name Occupation Employer City

How did you hear about us? \_\_\_\_\_

Do you have health insurance?  Yes  No Company: \_\_\_\_\_

***If yes, please present your card(s) to the receptionist for processing.***

BRIEFLY DESCRIBE YOUR HEALTH ISSUE(S): \_\_\_\_\_

When did it start? \_\_\_\_\_ What caused it? \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

What percentage of each day does it currently bother you? (Circle One) 0% 25% 50% 75% 100%

What would you like to do but can't because of this problem? \_\_\_\_\_

List other health care professional(s) seen for this condition: \_\_\_\_\_

**PERSONAL HEALTH HISTORY** – The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

### GENERAL CURRENT CONDITIONS

- Recent accident such as a fall, whiplash, or blow to the head
- Muscle spasms
- Numbness or tingling of hands or feet or radiating pain
- Headaches
- Migraines
- Depression
- Anxiety
- Dizziness
- Vision problem
- Nausea
- Restriction of movement
- Sleeping trouble
- Asthma or breathing problem
- High blood pressure
- Hearing problem
- Convulsions/epilepsy
- Heartburn/Acid Reflux
- Digestive trouble
- Menstrual problems
- Sinus problems
- Difficulty with stress
- Spinal disorder
- Shoulder, arm or hand problem
- Hip, leg or foot problem
- Jaw/mouth problem

### DIAGNOSED CONDITIONS

- Born with bone or joint disorder
- Degenerative arthritis
- Rheumatoid arthritis
- Compression fracture
- Heart attack or heart disorder
- History of stroke or aneurysm
- Cancer
- Diabetes
- Gout
- Lupus
- Ankylosing spondylitis
- Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- 3 or more months of steroid medications or intravenous drugs (past or present)
- Tuberculosis
- Hepatitis B or HIV infection
- Multiple sclerosis
- Thyroid or hormone disorder

### OTHER CONDITIONS:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### SPECIFIC PAIN IN THE BODY

- Neck pain with difficulty swallowing
- Extreme neck stiffness with pain or electric shocks in arm or legs when moving neck
- Leg pain that worsens with exercise
- Numbness of inner thighs
- Back pain with urinary problems
- Severe pain that interrupts sleep
- Constant pain that doesn't improve by changing positions or by lying down

### SPECIFIC CURRENT CONDITIONS

- Poor balance when walking or standing
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- Memory loss after injury
- Recent, unexplained weight loss
- Recent progressive muscle weakness or shaking
- Recent or current fever over 102°F
- Loss of bowel or bladder control

***Please continue on Page 2***

# Eaton Chiropractic Center

(Confidential Patient Information continued)

Name: \_\_\_\_\_

FAMILY HISTORY: (Circle all that apply)

Spine problems

Autoimmune disorders

Arthritis

Heart disease

Kidney disease

Cancer

Mental Illness

Seizures

Diabetes

Other: \_\_\_\_\_

Last known: Height \_\_\_\_\_ Weight \_\_\_\_\_ Are you pregnant?  Yes  No  X-rays or  MRI Date \_\_\_\_\_

Describe any surgeries or hospitalizations you've had and the dates: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Primary Care Physician/Medical Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How would you rate your diet? \_\_\_\_\_ What kind of exercise do you do weekly? \_\_\_\_\_

What do you do to mentally de-stress? \_\_\_\_\_

Do you feel you have a pretty good understanding of what CHIROPRACTIC is and how we treat?  Yes  Maybe  No

What are you currently doing to keep you and your family's spines healthy? \_\_\_\_\_

## Consent to Evaluation and Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by licensed Doctors of Chiropractic working at Eaton Chiropractic Center who now, or in the future treat me while employed by, working or associated with Eaton Chiropractic Center. I understand that I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvements of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

## Our Privacy Policy

Eaton Chiropractic Center is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the Eaton Chiropractic Center may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

By signing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Eaton Chiropractic Center

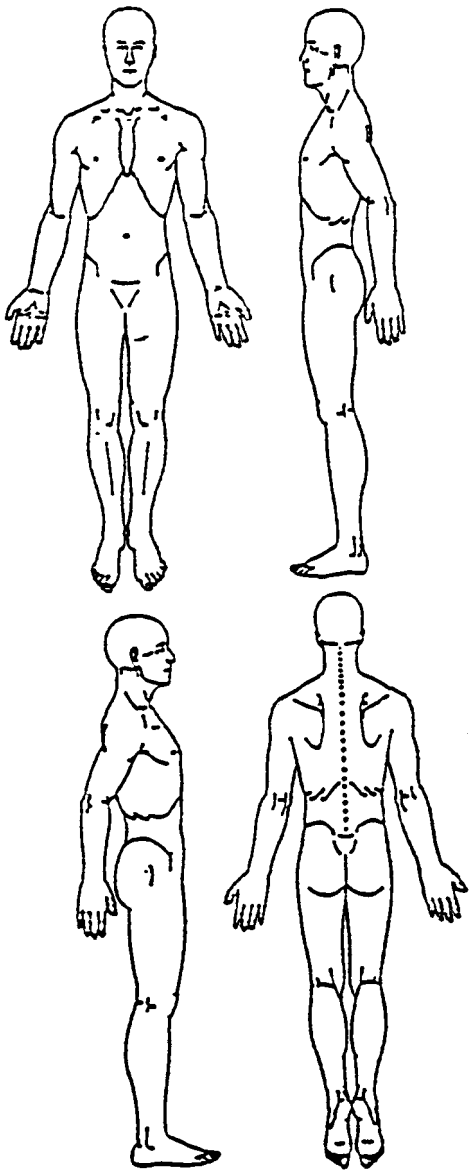
Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mark all areas of your body where you feel pain NOW  
Use the symbols below to describe the type of pain in the area of pain.

A = Aching      N = Numbness      P = Pins & Needles  
B = Burning      S = Stabbing      T = Throbbing  
Other (please describe): \_\_\_\_\_

*Draw At the Location of Your Pain*

*Rate Your Pain for TODAY*



0 No Pain

1

2

3

4

5

6

7

8

9

10

Severe Pain