Eaton Chiropractic & Rehab Center

1 Patient Information

Name: ___________________________
First *Initial* *Last*

Address: ___________________________

____
City *State* *Zip*

Home: ____________ Work: ____________

Cell: ____________ DOB: ____________

Sex: ☐ Male ☐ Female SSN: ____________

Email: ___________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Student *(If student skip to section 2)*

Employer Name: ___________________________

Employer Address: ___________________________

____
City *State* *Zip*

Spouse: ___________________________
First *Initial* *Last*

How did you hear about our clinic?: ____________

2 Insurance / Guarantor

Insurance Name: ___________________________

Ins ID: ___________________________

Group #: ___________________________

Subscriber's Name: ___________________________

Address: *(if different than patient)* ____________

____
City *State* *Zip*

DOB: ____________ SSN: ____________

Relationship to patient: ____________

Subscriber's Employer: ____________

Employee Address: ____________

____
City *State* *Zip*

3 Emergency Contact

Emergency Contact: ___________________________

Emergency Phone: ___________________________

Relationship: ___________________________

4 Accident Information

Is your condition due to an accident? ☐No ☐Yes ________
Date

Type of accident: ☐Auto ☐Work ☐Home ☐Other

Have you reported the accident to one of the following?

☐Auto Insurance ☐Employer ☐Worker Comp. ☐ Other

Attorney Name *(if applicable)*: ____________

5 Patient Condition

Reason for visit: ___________________________

When did symptoms first appear?: ____________

Is the condition getting progressively worse?

☐Yes ☐No ☐Unknown

How would you describe your pain? Mark all that apply:

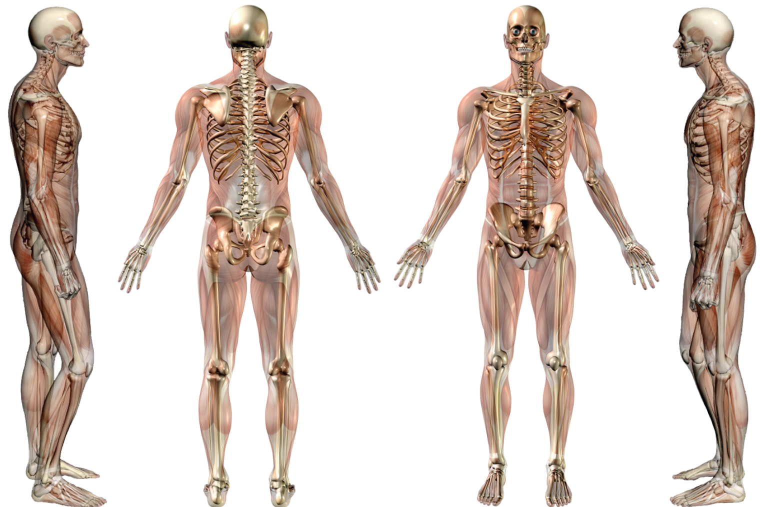
☐ Sharp ☐ Dull ☐ Throbbing
☐ Aching ☐ Shooting ☐ Burning
☐ Stiffness ☐ Cramping ☐ Other

Is the pain: ☐Constant ☐Comes and Goes

Have you had similar pain in the past? ☐Yes ☐No

If so, when?: ___________________________

Using the appropriate symbol, mark on the picture where you continue to have: Pain (X), Numbness (/), or Tingling (#)



____
Signature Date

6

Health History

Check treatments received for this condition? Chiropractic Medication None Physical Therapy Surgery

Name and location of other Doctor(s) treating you for this condition: ______________________________

____

Date of last: X-ray: ____________ MRI: ____________ CT-Scan: ____________ Bone Scan: ____________

Other (Specify): ______________________________

Place a "✓" to indicate if you currently have or have had any of the following:

Condition	Yes	No	Condition	Yes	No
Alcoholism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Allergy	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Anorexia / Bulimia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Anxiety Attacks	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Auto Immune Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Breast Lumps	☐ Yes	☐ No	Osteporosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Prostate Problems (Men)	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No	Sleep Problems	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Digestion Problems	☐ Yes	☐ No	Tumor/Growth (non-cancer)	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Herniated Disc	☐ Yes	☐ No		☐ Yes	☐ No

EXERCISE		WORK ACTIVITY		HABITS
☐ None	☐ Moderate	☐ Mostly Sitting	☐ Moderate Labor	☐ Smoking: Packs/Day ( )
☐ Daily	☐ Heavy	☐ Light Labor	☐ High Labor	☐ Alcohol: Drinks/Week ( )
Are you PREGNANT?	☐ Yes (Due Date:)	☐ No	☐ Maybe	☐ Coffee/Pop # per day ( )

Please describe any of your **SURGERIES** or **BROKEN BONES**? Give dates.

Surgeries: ______________________________

Broken Bones: ______________________________

Any other conditions not covered on this form? ______________________________

____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS

7

Assignment & Release

If you have insurance, please make sure that you give your card to the front desk person so they can make a copy of your information.

I, the undersigned, certify that I (or my dependent) have Insurance coverage and assign directly to Eaton Chiropractic & Rehab Center, P.C. all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

Guarantor's Signature: ______________________________ Date: ____________