

Personal History

Date: _____ Driver's License # _____ Social Sec # _____
Name: _____ Medicare: YES or NO
Address _____ If Medicare, need copy of card & signature
City: _____ St. _____ Zip _____
Phone Home: _____ Work: _____ Mobile: _____
Email Address: _____ Fax: _____
Birth Date: _____ Sex _____ Height _____ Wt _____
Occupation: _____ Employed by: _____

Circle if you are: Married Single Widowed Divorced Separated

Overall Health: Excellent / Good / Fair / Poor 0-10 scale (10 being best) _____

Health Concern: (what you are here for) _____

Other Care Received for Health Concern: _____

Results? _____

Are you currently under the care of a health care practitioner for this concern? YES NO

Have you been involved in any accidents in the past 5 years? Yes No Pending cases? Yes No

REFERRED BY: _____

Do you Take or use?:

Nutritional Supplements NO Yes (list) _____

Medications NO Yes (list) _____

Special Diet NO Yes (list) _____

Coffee NO Yes Brewed Instant How many cups per day? _____

Soft Drinks NO Yes Diet Regular How many cans per day? _____

Candy / Sweets NO Yes (list) _____

Tobacco products NO Yes (list) Chew Cigar Pipe Cigarettes per day _____

Allergies NO Yes (list) _____

Animals in your home NO Yes (list) _____

Dental Work NO Yes (list what & when) _____

Major Life Event NO Yes (list what & when) _____

Disease: (circle any you have had):

Appendicitis	Malaria	Chicken Pox	Alcoholism
Scarlet Fever	Tuberculosis	Diabetes	Venereal Infection
Hepatitis	Whooping cough	Cancer	Arthritis
Typhoid Fever	Anemia	Heart Disease	Epilepsy
Pneumonia	Measles	Goiter	Mental Disorder
Rheumatic Fever	Mumps	Influenza	Lumbago
Polio	Small Pox	Pleurisy	Eczema

Describe further or list any other disease: _____

Surgeries: _____

Family Health History

Relation	Name	Age	Present Symptoms	Previous Serious Illness
Spouse				
Children				
Father				
Mother				
Sister				
Brother				

Anything you would like to be certain we understand about your case?

PLEASE CIRCLE THE TYPE OF CARE DESIRED BELOW AND SIGN

Chiropractic / Nutrition / Both Chiropractic & Nutrition / Doctor Recommended Best Type of Care

=====

Please read before signing:

I authorize the health care personnel of this office to evaluate the information I have provided them and the information they will further gather to consider various options available to me to improve my health, vitality and well-being and not for the treatment, or "cure" of any disease.

I give the office staff permission to contact me by phone, mail, email or fax to discuss with me or inform me about what might be helpful for me or my family. I understand this permission to contact me can be rescinded by me at any time* I choose.

I understand that I am responsible for payment in full at the time of service and that I will be provided with a receipt at the time of service to submit to my insurance for reimbursement, if applicable.

Signed _____ Date _____ (If minor, signature of parent or guardian required)

*Rescinding of permission accepted in writing only

Chiropractic & Nutritional Informed Consent

Every type of health care is associated with some risk of potential problems. This includes chiropractic & nutritional care. Although research has shown that chiropractic & nutritional care are some of the safest forms of treatment, we want you to be informed about potential associated problems before consenting to treatment. This is called informed consent.

Chiropractic Informed Consent:

Chiropractic adjustments are gentle movements of the joints with the doctor's hands or with the use of a mechanical device. The following are potential situations that could arise from an adjustment:

- Soreness: most always a temporary symptom that occurs while your body is undergoing change.
- Rib fractures: very rarely will an adjustment fracture a rib; this could occur on patients who have weakened bones from such things as osteoporosis.
- Soft tissue injury: tearing of muscle or ligament fibers; also rare and no long-term effects for the patient.
- Disc herniations: rarely will chiropractic care aggravate an already herniated disc and rarely may surgery become necessary to correct.
- Stroke: very rarely- an estimated incidence is 1 per every 3 million upper neck adjustments; it could be involved only if patient has cardiovascular insufficiency.

Nutritional Informed Consent:

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." Although a vitamin, mineral, trace element, amino acid, herb, or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean they can be misrepresented or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

I hereby, attest to the following:

1. I have read the above and understand the possible risks and hazards of chiropractic treatment.
2. The services performed by Dr. Eric Snow are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that the recommendations, discussion, sale of food, nutrition, nutrition supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, or prescribing of medications, or any act, which will constitute the practice of medicine in this state, for which a medical license is required.

Signature: _____ Date: _____

Print Name: _____ Child/Minor Name: _____

Relationship: _____

Authorization to Release Medical Records

I, _____, hereby authorize you to release to Dr. Eric Snow, D.C., any information in my personal medical records, including all x-rays, MRI reports, blood labs and any other information pertinent to my treatment under your care.

(Print) Full name of Patient: _____

Date of Birth of Patient: _____

Social Security Number of Patient: _____

Signature of Patient/Guardian: _____

Date: _____

Please send all information to:

Dr. Eric Snow, D.C.
721 East Bayou Pines Drive
Lake Charles, LA 70601
Fax (337) 436-3270
Phone (337) 478-1313
Email: info@drericssnow.com

HEALTH EXAM FORM

Date: _____

Patient Name: _____

Please fill this out with your primary concern(s) TODAY regardless if Chiropractic or Nutrition or Both

Primary Concern(s): _____

Onset: When did this start?

Palliative: What helps your condition?

Provocative: What worsens your condition?

Quality: Describe your symptoms.

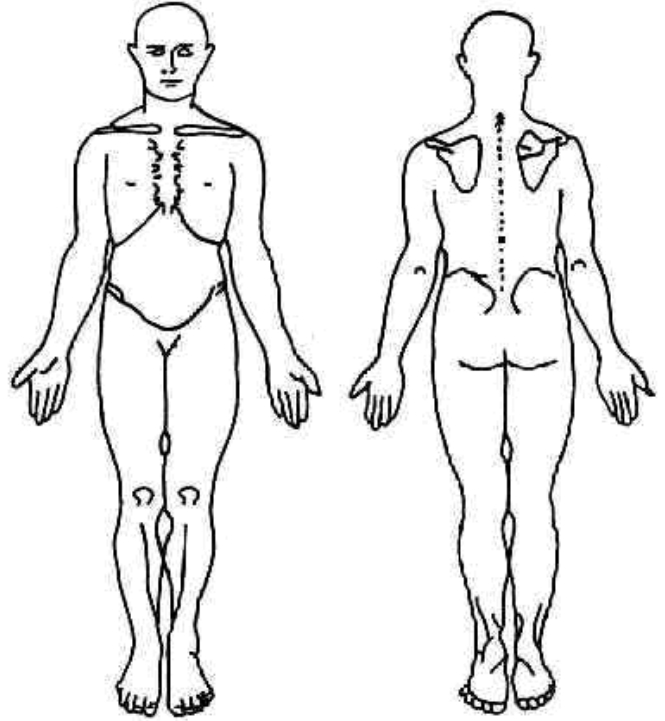
Referral: Does your pain travel / radiate / where?

Site: Where are your symptoms located?

(Please use the graphic and key to the right to indicate the type & location of your pain & sensations)

Timing: What time or times of the day do you notice symptoms?

KEY	
A= Ache	N= Numbness
B= Burning	P= Pins & Needles
S= Stabbing	O= Other



Please indicate the level of pain you are experiencing										
0	1	2	3	4	5	6	7	8	9	10
No Pain					Severe Pain					

(OFFICE USE ONLY)

SPINAL RANGE OF MOTION:

CERVICAL ROT LAT EXT FLEX

THORACIC ROT LAT EXT FLEX

LUMBAR ROT LAT EXT FLEX

REFLEX: ACH PAT BI TRI BR

BALANCE TEST: EO ___/___ EC ___/___

Chiropractic Recommendations: CRE-P CRE-F CRE-R

Adjustment ___ per week / month for ___ visits

VB LASER RR TPT

Other Recommendations: _____

Continue Corrective Care Move to Maintenance Care

ORTHO: MAIGNE'S (VERTBRAL ARTERY): NEG

TOE WALKING (L5/S1): NEG

HEEL WALKING (L4/L5): NEG

KEMP'S: NEG SOTO: NEG VALSAL: NEG

DISC SCREENING:

LEG LIFT: NEG

CERV COMPRESS: NEG

SHORT LEG: L R

PALPATION REMARKS: _____

PULSTAR / PRINT SCAN _____ (Staff Initials)

(IE ONLY) C N B Commitment_____

DOCTORS SIGNATURE:

Name _____

Date _____

SURVEY OF YOUR OVERALL HEALTH OF YOUR BODY'S SYSTEMS

For your FIRST VISIT-checkmark any symptom you have experienced in last 6 MONTHS.

For RE-EXAMS-checkmark symptoms you are CURRENTLY experiencing.

HEADACHES

___ Base of Skull (back)
 ___ Side of head (temples)
 ___ Frontal (above eyes)
 ___ Top of head
 ___ Entire Head
 ___ Migraines
 ___ Cluster
 ___ Other _____

EARS

___ Noise (Ring / Hiss / Pound)
 ___ Plugged
 ___ Popping
 ___ Ear Ache
 ___ Ear Infections
 ___ Itchy Ears
 ___ Ear Drainage
 ___ Hearing Loss
 ___ Excessive Ear Wax
 ___ Dizziness/ Vertigo
 ___ Other _____

EYES

___ Burn
 ___ Tear
 ___ Ache
 ___ Red
 ___ Dry
 ___ Eye Film
 ___ Crust in morning
 ___ Itchy Eyes
 ___ Bouts of Blurriness
 ___ Floaters
 ___ Spots
 ___ Tired
 ___ Puffy
 ___ Style
 ___ Twitching around eyes
 ___ Dark Circles
 ___ Light Bothers Eyes
 ___ Nearsighted
 ___ Farsighted
 ___ Other _____

SINUS

___ Nosebleeds
 ___ Dry
 ___ Drain
 ___ Stuffy/ plugged up
 ___ Sneeze frequently
 ___ Smell Loss
 ___ Taste Loss
 ___ Post nasal drip...circle color:
 white / yellow / green / gray
 brown / blood / blood / clear
 ___ Other _____

MOUTH/ THROAT/ IMMUNE

___ Blisters
 ___ Canker Sore
 ___ Bad Breath
 ___ Bleeding gums
 ___ Receding gums
 ___ Teeth Health Problems
 ___ Dry Mouth
 ___ Swelling of Glands
 ___ Difficulty Swallowing
 ___ Sore Throat
 ___ Hoarseness
 ___ Fever
 ___ Chills
 ___ Cold/ sweaty hands or feet
 ___ Cough (dry / productive)
 ___ Environmental Allergies
 ___ Upper Respiratory Infection
 ___ Frequent Colds/ Flu
 ___ Chronic Bronchitis
 ___ Other _____

CHEST

___ Tension
 ___ Tight
 ___ Pressure
 ___ Heaviness
 ___ Congestion
 ___ Chest Pain
 ___ Sternal Pain
 ___ Sharp Heart Pain
 ___ Palpitations-Heart Skip / Flutter
 ___ Heart Racing
 ___ Heart Slowing down
 ___ Mitral Valve Prolapse
 ___ Murmur
 ___ Other _____

SHORTNESS OF BREATH

___ Constant (mild / mod / severe)
 ___ Upon Exertion (mild / mod / severe)
 ___ Wheeze
 ___ Air Hunger
 ___ Asthma
 ___ Frequent Sighs
 ___ Emphysema
 ___ Other _____

STOMACH

___ Heartburn
 ___ Indigestion
 ___ Stomach Aches
 ___ Stomach Cramps
 ___ Nausea / Queasy
 ___ Bloat after Eat
 ___ Gas / Flatulence
 ___ Belching
 ___ Ulcer
 ___ Hiatal Hernia
 ___ Other _____

BOWELS

___ Bowel Movements ___ Per day
 ___ Regular
 ___ Incomplete
 ___ Skip days ___ per (week / month)
 ___ Sluggish bowels every ___ days
 ___ Cramps in Abdomen
 ___ Taking Laxatives
 ___ Using Suppositories
 ___ Enemas
 ___ Colonics
 ___ Bulky
 ___ Pain with Bowel Movements
 ___ Irritable Bowel Syndrome
 ___ Chrons
 ___ Colitis
 ___ Other _____

FECAL CONSISTENCY

___ Color feces light or dark
 ___ Normal
 ___ Soft
 ___ Hard
 ___ Pebbles
 ___ Dry
 ___ Ribbon-like
 ___ Mucous
 ___ Diarrhea
 ___ Constipation
 ___ Other _____

HEMORRHOIDS

___ Swollen
 ___ Burning
 ___ Blood
 ___ Distended
 ___ Itchy
 ___ Stinging
 ___ Achy

URINATION

___ times per day-frequency
 ___ Urinate at night ___ per night
 ___ Urgency
 ___ Burning
 ___ Pain
 ___ Odor
 ___ Spasm
 ___ Leakage
 ___ Incontinence
 ___ Cloudy urine
 ___ Urinary Tract Infection
 ___ Kidney Troubles
 ___ Other _____

ENERGY

___ Low
 ___ Variable
 ___ Normal
 ___ High
 ___ Slow to start in the morning
 ___ Low Energy after meals
 ___ Energy Crash ___ am/pm
 ___ Other _____

SLEEP

___ Quality (poor / fair / good / great)
 ___ Hours in bed
 ___ Hours asleep
 ___ Difficulty falling asleep
 ___ Difficulty staying asleep
 ___ Interrupted ___ per night
 ___ Crave Sleep during day
 ___ Awaken Suddenly (Jolt)
 ___ Don't Remember Dreams
 ___ Nightmares
 ___ Night sweats
 ___ Restlessness
 ___ Sleep Apnea
 ___ Other _____

EMOTIONS

___ Stress
 ___ Sad
 ___ Grief
 ___ Depression
 ___ Moodiness
 ___ Frustrated
 ___ Irritable
 ___ Angry
 ___ Worrisome
 ___ Nervous
 ___ Anxiety
 ___ Panic
 ___ Cry
 ___ Fear
 ___ Shame
 ___ Other _____

APPETITE/ DIET

___ Appetite (Low, Norm, High)
 ___ Eat Starch (pasta/bread/potatoes/rice)
 ___ Eat Sweets (cakes, cookies, candy)
 ___ Eat Chocolate
 ___ Eat Spicy Foods
 ___ Eat Ice Cream ___/per week
 ___ Coffee ___cups/ day
 ___ Caffeinated Tea ___cups/day
 ___ Beer ___per week
 ___ Wine ___per week
 ___ Liquor ___per week
 ___ Juice ___per week
 ___ Soda ___per week
 ___ Eat Artificial Sweeteners
 ___ Eat Trans Fats

EXERCISE

___ Cardiovascular ___ times/ week
 ___ Weight Train ___times/per week

MEMORY

___ Forget Names
 ___ Forget Numbers
 ___ Forget Words
 ___ Forget Actions
 ___ Difficulty Concentrating
 ___ Other _____

LIBIDO/ SEXUALITY

___ Flat
 ___ Low
 ___ Normal
 ___ Erectile Dysfunction (men)
 ___ Orgasm Quality (poor / good / great)
 ___ Other _____

SKIN/ HAIR/ NAILS

___ Skin Rash
 ___ Acne
 ___ Dry Skin
 ___ Itchy Skin
 ___ Patches skin look different
 ___ Cellulite
 ___ Nails (weak / spots / lines)
 ___ Nail fungus (mild / mod / severe)
 ___ Hair loss
 ___ Limp Hair
 ___ Other _____

CRAMPS/ ACHES/ RESTLESS

___ Cramps (legs / feet / arms / hands)
 ___ Aches (legs / feet / arms / hands)
 ___ Restless (legs / feet / arms / hands)
 ___ Other _____

PROSTATE (men only)

___ Burn
 ___ Achyness
 ___ Pain
 ___ Restriction
 ___ Dribbling
 ___ Emission
 ___ Swelling
 ___ Last Prostate exam/PSA date _____

MENSES (women only)

___ Last Menstrual Period _____
 ___ Length of Menses _____
 ___ Regular ___ Irregular
 ___ Pregnant/Possibility Yes No
 ___ Early (less than 28 days)
 ___ Late (more than 28 days)
 ___ Skip
 ___ Birth Control Pill
 ___ Flow (heavy / moderate / light)
 ___ Clotting/ Spotting
 ___ Cramps (mild/ mod/ severe)
 ___ Low Abdominal Puffiness
 ___ Fluid Retention Face
 ___ Fluid Retention Hands
 ___ Fluid Retention Feet
 ___ Tired during cycle
 ___ Acne (pre / mid / post)
 ___ Mood swings / Irritable / Depression
 ___ Breast Tender around cycle

VAGINA (women only)

___ Burn
 ___ Itch
 ___ Dry
 ___ Pain
 ___ Blood
 ___ Discharge-clear/color _____
 ___ Last Female exam/Pap Date _____

PATIENT SIGNATURE

DATE

 Consistency taking supplements _____%

BREASTS (women only)

___ Breast Tender constant
 ___ Breast Feeding
 ___ Fibrosis
 ___ Lump
 ___ Discharge
 ___ Prosthesis
 ___ Augmentation Surgery
 ___ Reduction Surgery
 ___ Pathology
 ___ Last Mammogram/Therm date _____

MENOPAUSE (women only)

___ Natural
 ___ Surgical (partial / complete)
 ___ Hormones
 ___ Patch
 ___ Hot Flashes
 ___ Skin Crawling
 ___ Cherry Hemangiomas
 ___ Facial Hair
 ___ Hair growing up towards belly button
 ___ Dark Nipple Hair
 ___ Other _____

List Your Primary Concerns in order of importance to you:

1) _____
 2) _____
 3) _____
 4) _____

For Doctor's Use

___ Luna Fingernails Rt 1 2 3 4 5 Lt 1 2 3 4 5
 ___ Splinter Hemorrhages
 ___ Ear Creases (Rt/ Lt) mild / mod / severe
 ___ Cherry Hemangiomas
 ___ Lateral Eyebrows Thinning
 ___ Frenular Cyst
 ___ Color Tongue _____
 ___ Coated Tongue (mild / mod / severe)
 ___ Cracks in Tongue-midline/ all over
 ___ Allergy Patches Tongue
 ___ Red Spots Tongue
 ___ Swollen Tongue
 ___ Dark Veins under Tongue

Weight _____
 BP _____ / _____ Supine _____ Pulse
 BP _____ / _____ Standing _____ Pulse
 Waist _____ Hip _____ Ratio _____
 O₂ Sat _____
 pH _____
 Zinc 0 1 2 3 4 5 6 7 8 9 10
 Moisture _____
 Calcium _____

Allergies _____
 Surgeries _____
 Current Meds: _____

CA Initials _____ Date: _____

Notes: _____

 Goals: _____
