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) _______________________

Have you ever been diagnosed with diabetes? NO YES

Have you ever been diagnosed with cancer? NO YES

Are you currently on or have you taken blood thinners or steroids in the past 6 months? NO YES

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

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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

Informed Consent

Every type of health care is associated with some risk of potential problems. This includes Chiropractic care, Instrument-assisted Soft Tissue Mobilization/Manual Soft Tissue Mobilization/Myofascial Disruption Technique (ISTM/MSTM/MFDT) and Nutritional Care. Although research has shown that Chiropractic Care, Soft Tissue Mobilization Techniques & 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 the patient has cardiovascular insufficiency.

Therapy Informed Consent:

ISTM uses patented stainless-steel instruments that are designed to adapt to the various tissue conformations. This allows us to detect and treat soft tissue dysfunctions in a precise and specific manner. MFDT & MSTM are body work techniques that use deep pressure to correct fatigue, trigger points, adhesions and disruptions in the muscles and connective tissue. They are also used to re-anchor tendons and ligaments after sprain/strain injuries.

The following are potential situations that could arise from therapy:

- Patients may experience pain or discomfort during treatment. In addition, bruising or a significant soft tissue release is possible subsequent to ISTM, MFDT or MSTM. Using cryotherapy (Cold/Ice Therapy) after treatment can lessen associated side effects.

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 treatments.
2. The services performed by Snow Holistic Health 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 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@drericsnow.com

HEALTH EXAM FORM Date: _______________

Patient Name: ____________________________________

Primary Concern: ________________________________

Onset: When did this start?

Palliative: What helps your condition?

Proactive: What worsens your condition?

Quality: Describe your symptoms.

Referral: Does your pain travel/radiate?

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)

Home _________________ Work ___________________

Out Act _______________ Motivation _______________

Toe Walking (L5/S1): NEG POS

Heel Walking (L4/L5): NEG POS

BALANCE TEST: EO ___/___ EC ___/___
R L R L

REFLEX: ACH PAT BI TRI BR

SPINAL RANGE OF MOTION:

CERVICAL	ROT	LAT	EXT	FLEX
THORACIC	ROT	LAT	EXT	FLEX
LUMBAR	ROT	LAT	EXT	FLEX

Chiropractic Recommendations: ☐CRE-P ☐CRE-T ☐CRE-R

Adjustment ___ per week / month for _____ visits

VB LASER RR STAB VP

Other Recommendations: _________________________

☐ **Continue Corrective Care** ☐**Move to Maintenance Care**

KEMP'S: NEG POS

VALSAL: NEG POS

CERVICAL COMPRES: NEG POS

MAIGNE'S (VERTBRAL ARTERY): NEG POS

SOTO: NEG POS

LEG LIFT: NEG POS R L

SHORT LEG: R L

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
___ Stye
___ 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
___ Stingy
___ 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 wek
___ 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 Hemmorages
___ Ear Creases (Rt/ Lt) mild / mod / severe
___ Cherry Hemangiomas
___ Lateral Eyebrows Thining
___ 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 ______
O_2 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:__________________________
____