Eckert Chiropractic Center, P.C. Alternative & Complimentary Medicine

Chiropractic Patient Information

First Name:	Last Name:	Date of Birth:
Home Phone:	Mobile Phone:	Work Phone:
Email:	Preferred Communication: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Email	
Street Address:	Apt/Suite #:	
City:	State:	Zip Code:

SSN:	Gender: ☐ Female ☐ Male	Preferred Language: ☐ English ☐ Other
Race & Ethnicity: ☐ American Indian or Alaska ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native Hawaiian ☐ White ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other	
Emergency Contact Name:	Phone #:	Relationship:

Primary Care Provider Name:	Phone Number:
Street Address:	Apt/suite #:
City:	State: Zip Code:

Employer / Company Name:	Phone Number:
Street Address:	Apt/Suite #:
City:	State: Zip Code:
Job Title/Position:	Currently Working: ☐ Yes ☐ No Date Stopped Working:

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Financially Responsible Party ☐ Self ☐ Other (If Other Please Complete Section Below)

First Name: | Last Name: | Date Of Birth:

Relationship With Patient: | Home Phone: | Mobile Phone: | Work Phone:

Street Address: | Apt/Suite #:

City: | State: | Zip Code:

Reason For Your Visit:

☐ Nutritional Wellness | Height: | Weight:

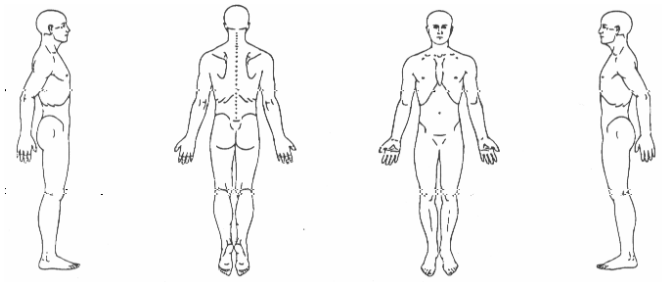
Date of Injury or When Did Your Complaint Start?

☐ Injury or General Complaint

☐ Accident ☐ Auto Accident ☐ Other Accident | Date Of Accident: | State: Where Accident Occurred:

Please Provide Brief Details Of Your Injury, Complaint, or Accident:

Circle The Areas Where You Hurt



How Often Do You Feel Pain:

☐ Constant (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

Check All That Describe Your Pain

☐ Aching ☐ Burning ☐ Dull ☐ Sharp
☐ Stabbing ☐ Stiffness ☐ Weakness ☐ Numbness / Tingling

Please Mark The Severity Of Your Pain

No Pain — Unbearable

0 1 2 3 4 5 6 7 8 9 10

What Aggravates Your Condition (Check All That Apply)

☐ Heavy Activity ☐ Moderate Activity ☐ Light Activity ☐ Bending
☐ Lifting ☐ Standing ☐ Stress ☐ Tempurature Change

What Relieves Your Condition (Check All That Apply)

☐ Cold ☐ Heat ☐ Increased Actifity ☐ Lying Down ☐ OTC Medication
☐ Postural Change ☐ Rest ☐ Stretching ☐ Support Brace ☐ Prescription Meds.

Life Style					
Are You A Smoker?	☐ Yes	☐ No	If Yes How Often?		/Day/week
Do You Drink Alcohol?	☐ Yes	☐ No	If Yes How Often?		/Day/week
Do You Exercise?	☐ Yes	☐ No	If Yes How Often?		/Day/week
Have You Been Hospitalized?	☐ Yes	☐ No	Have You Had Surgeries?	☐ Yes	☐ No
If Yes, Please List Dates and Details					
Do You Have Any Allergies?	☐ Yes	☐ No	Do you Require Medical Treatment For Your Allergies?		
If Yes, Please Provide Details:					

List Medications	Condition Prescribed For	List Vitamins Taken

How Did You Hear About Our Office

All patients in the State Of Missouri are required to approve all services rendered by their doctor before any services are performed. Refusal to comply with Missouri Law releases your doctor of all liabilities and his/her right to refuse treatment.

I hereby request and give consent to my doctor to perform all necessary chiropractic examinations, adjustments, therapy, rehabilitation, and medical diagnostic x-rays. I understand that my doctor will consult with me before any procedures are performed, at which time, I will give him permission to perform all necessary procedures to treat my condition. I understand that I have any opportunity to discuss with the doctor and / or with the office manager, the nature and purpose of my chiropractic care before any treatment is rendered.

Signature _____ Date _____