

# Personal History

Date: \_\_\_\_\_ Driver's License # \_\_\_\_\_ Social Sec # \_\_\_\_\_

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

Address \_\_\_\_\_

City: \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Phones 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 health care practitioner for this concern? 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    \_ \_\_\_\_\_

Do you have animals in your home? NO    Yes (list) \_\_\_\_\_

Operations / Surgeries    NO    Yes (list) \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

# Family Health History

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

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

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PLEASE CIRCLE THE TYPE OF CARE DESIRED BELOW AND SIGN

Temporary Relief                      Lasting Correction                      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.

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

\*Rescinding of permission accepted in writing only

Use the letters listed below to indicate the type and location of your pain and sensations:

**KEY**

A = ACHE

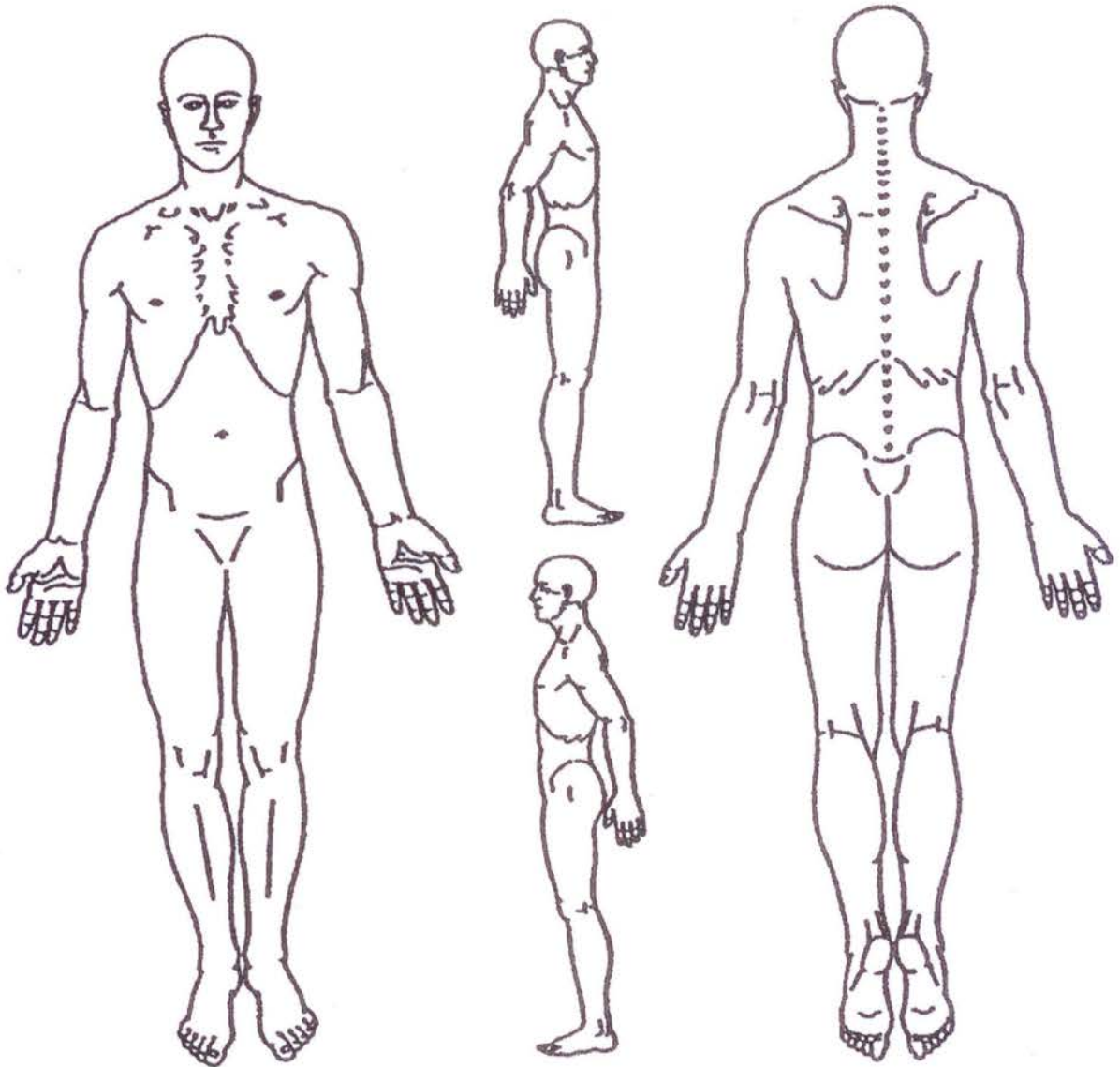
B = BURNING

S = STABBING

N = NUMBNESS

P = PINS & NEEDLES

O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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 and any other information pertinent to my treatment under your care.

Full name of Patient: \_\_\_\_\_

Social Security Number of Patient: \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Please send all information to:

Dr Eric Snow, D.C.  
810 W Bayou Pines Drive  
Lake Charles, LA 70601  
Fax (337) 436-3270  
Phone (337) 478-1313  
Email: [eric@drericsnow.com](mailto:eric@drericsnow.com)

# 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 care is one of the safest forms of treatment, we want you to be informed about potential problems associated with it before consenting to treatment. This is called 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 a therapeutic change. The doctor will show you ways to manage this.
- 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.

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.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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

Child/Minor Name: \_\_\_\_\_ Relationship: \_\_\_\_\_