Philip E Snowden, DC
4368 South Alameda
Corpus Christi, Texas 78412

PATIENT INFORMATION

Last Name _____ **First Name** _____ **Middle** _____

Home Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Email _____ **Cell Phone Provider** _____

Gender: M F Date of Birth ____ / ____ / ____ **Marital Status (M) (S) (W) (D)**

***Referred By** _____

Employer

Name _____ **Phone** _____

Occupation _____

PRIMARY INSURED

Last Name _____ **First Name** _____ **Middle** _____

Employer Name _____ **Phone** _____

EMERGENCY: Name and address of nearest relative or friend not living with you.

Last Name _____ **First Name** _____

Home Phone _____ **Cell Phone** _____

Relation to Patient _____

MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____ **Date** _____

Signature of patient or person acting on patient's behalf

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MEDICAL AND HEALTH HISTORY

MAIN PROBLEM:

What pain causes you to come to the office?_____

What caused this pain? _____

When did this pain start? _____ **This pain occurs? (Circle one) Occasional, Frequent, Constant**

How bad is this pain? (Circle one - 1 mild pain - 10 intense pain) 1 2 3 4 5 6 7 8 9 10

Circle the word or words that best describe the pain: _____
Dull Ache, Sharp, Shooting, Throbbing, Burning, Numb, Radiating, Stabbing, Tightness, Tingling

Does this pain travel to any other area? _____

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain? _____

OTHER HISTORY:

Do you smoke? YES NO If yes, how many per day? _____**Any known allergies?**_____

Do you exercise regularly? YES NO If yes, how often? _____

Are you pregnant? YES NO Date of last physical exam? _____

Have you ever been to a chiropractor before or had acupuncture? YES NO If yes, with whom? _____

Have you ever seen a doctor for this condition? YES NO If yes, who? _____

Are you currently under treatment for ANY other condition? YES NO If yes, please explain
_____

Have you had any accidents or injuries in the past? _____

List any surgeries you have had _____

List any medications you are currently taking and reason for taking them:
_____

_____

FOR STAFF ONLY

Case Type:_____**BP/Pulse**_____**Height:**_____**Weight:**_____**Temp:**_____**Oxy:**_____

Defibrillator:_____**Pacemaker:**_____**R.O.M. - Cervical: Left:**_____**Right:**_____

Lumbar: Flexion:_____ **Extension:**_____

SYSTEM REVIEW: **(Only check boxes that apply)**

General: ☐ recent weight change ↑ ↓ ☐ weakness/fatigue ☐ fever ☐ chills ☐ night sweats

EENT: ☐ ringing in ear R L ☐ hearing loss ☐ dizziness ☐ double vision ☐ blurred vision ☐ difficulty swallowing
☐ sinusitis ☐ hoarseness ☐ speech difficulties ☐ frequent nose bleeds ☐ swollen glands ☐ allergies

Muscle/Joint: ☐ joint swelling ☐ cramps ☐ arthritis ☐ rheumatoid arthritis ☐ osteoarthritis
Gout: ☐ right ☐ left ☐ bruise easily ☐ anemia ☐ blood clots legs/lungs

GI: ☐ loss of appetite ☐ bowel problems ☐ bloody stool ☐ nausea or vomiting
☐ hiatal hernia ☐ abdominal pain ☐ heartburn ☐ indigestion ☐ liver disease

Neuro: ☐ anxiety ☐ headaches ☐ depression ☐ stroke ☐ fainting spells ☐ head injuries
☐ depression ☐ memory loss

Endocrine: ☐ diabetes ☐ change in skin texture ☐ cold intolerance ☐ heat intolerance

Respiratory: ☐ asthma ☐ shortness of breath ☐ wheezing ☐ bronchitis ☐ pneumonia

Cardiovascular: ☐ angina ☐ leg cramps ☐ cold hands/feet ☐ dizziness when stand up quickly
☐ high or low blood pressure ☐ leg pain that resolves with rest ☐ chest pains ☐ varicose veins ☐ pacemaker

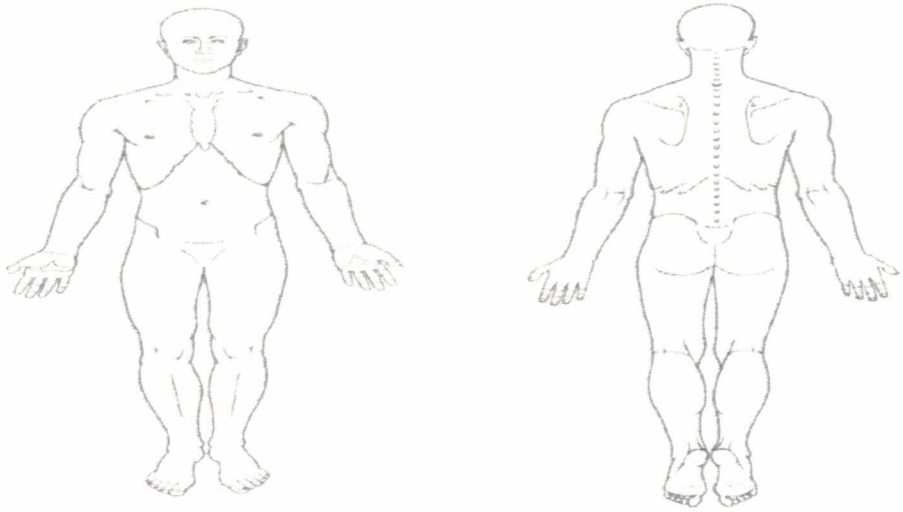
Kidney/U.T.: ☐ blood in urine ☐ painful urination ☐ excessive thirst ☐ bladder infections
☐ urinating frequently (day) (night) ☐ kidney stones ☐ kidney disease

Skin: ☐ rashes ☐ boils ☐ hives ☐ dry skin ☐ lumps ☐ psoriasis ☐ nail problems
☐ moles – irregular ☐ moles – change/new

FAMILY HISTORY: **M-mother, F-father, S-sister, B-brother, GP-grandparents (check and circle)**

☐ High Blood Pressure (M)(F)(S)(B)(GP)
☐ Heart Disease (M)(F)(S)(B)(GP)
☐ Thyroid Disease (M)(F)(S)(B)(GP)
☐ Kidney Disease (M)(F)(S)(B)(GP)
☐ Diabetes (M)(F)(S)(B)(GP)
☐ Asthma/Emphysema (M)(F)(S)(B)(GP)
☐ Migraine (M)(F)(S)(B)(GP)
☐ Seizures (M)(F)(S)(B)(GP)
☐ Anemia (M)(F)(S)(B)(GP)
☐ Arthritis (M)(F)(S)(B)(GP)
☐ Cancer (M)(F)(S)(B)(GP)

Please circle where you hurt



SNOWDEN CHIROPRACTIC CLINIC
4368 S. ALAMEDA St
Corpus Christi, TX 78412

(INFORMED CONSENT)

I hereby request and consent to the performance of chiropractic adjustments and/or acupuncture on me (or on the patient named, for whom I am legally responsible) by Dr. Philip Snowden, DC.

I have had an opportunity to discuss with Dr. Snowden, or a member of his staff, the nature and purpose of chiropractic adjustments and/or acupuncture and I understand the results are not guaranteed.

I understand and am informed that as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient Signature _____Date: _____

Witness Signature _____ Date: _____