Welcome to Eagle Sport and Family Chiropractic

In order for us to give you the attention you deserve on your path to wellness, we ask you to please be aware of the Center's Mission, Philosophy, and Policies:

Our Mission is to assist you in achieving physical, spiritual, and emotional well-being.

Our Philosophy is to educate and empower you to live in optimal wellness. This approach is comprehensive and compliments any existing health care program.

Tardiness Please be courteous and arrive on time for your scheduled appointment. Late arrivals force us to deduct time from your appointment in order to keep the schedule for other clients throughout the day.

Anyone arriving more than five minutes past their scheduled time will need to rebook their appointment.

Cancellations We do request a minimum of 24 hours advance notice for any cancellation or rescheduling of your appointment. This is a consideration to our practitioners. Short notice or no notice will result in an office visit charge.

Payment of Services Payment in full is expected at the time of service. The Center receives payment in cash, check, credit and debit form. However, most of our practitioners are independent so please verify the appropriate payment with each of them individually.

Returned Checks A standard fee of $25.00 will be charged for any returned checks.

I have read and understand the Center's mission, philosophy and policies.

Print Name: ______________________________

Signature: ______________________________

Date: ____________________

New Client Information, page 1

Please print clearly. Complete page 1 and page 2.

Name: ____ Date: ____________

Address: ____ Apt. # ___________

City: ____________________ State: _________________ Zip: ______________

Shipping Address: ____

Home Phone:(___)_____-_____________ Work Phone:(___)____-_____________
Cell Phone:(____) _____-_____________ **Circle preferred phone** home work cell
Email Address: ____________________@_____________________________
Appointment reminders: text email phone call
Referred by: ____
Occupation: _____________________ Employer: ______________________
Date of Birth: __________________ Age: ______ Height: ______ Weight: ______

Current Complaints (reason you are here): __________________________________

____

____

Current medications/drugs being taken with dosages: __________________________

____

____

Are you currently under the care of a physician or other health care professionals? If yes, please give name: ______________________________________

____

Are you currently taking vitamins, herbs or nutritional supplements? If yes, please list:

____

____

Personal Habits: Do you use the following and if so, how much?
Cigarettes_________________ Coffee_________________ Alcohol______________
Soda ______________ Sugar______________ Non prescription drugs ____________

____

____

____

____

____

New Client Information, page 2

Name: ________________________________ Date: ____________________

HEALTH HISTORY:

List any major illnesses, injuries, surgeries (with approx. dates):

____
____
____
____
____

Any major scars or body piercings (please list):______________________________
____
____

# of pregnancies: ________________ Are you currently pregnant: Y/N

Marital status (please circle): Single, Married, Divorced, Widowed

Name of Spouse or Partner: ______________________________

Describe health of Spouse or Partner: ________________________

# of Children: ______ Any concerns or health issues (if so, please list):

____
____
____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Stroke / Other: ____
____

Any household pets or other animals you or family members are in close contact with:

____

How can we help you? ____
____
____

SIGNED: ________________________________ **DATE:** ______________

Eagle Sport and Family Chiropractic
Consent to Treat

Name:______________________________ Date:________________

Address:____

Phone:______________________________

Age: __________ Height: __________ Weight: __________ Body Fat: __________

Comments:____

Client Goals:____

Recommended Nutritional Supplementation:

Disclosure: I understand that Dr Kraig Knotts is recommending the above supplementation, nutritional program, and or treatment; i.e. Whole body Vibration, Infrared Sauna based upon his understanding and experience as a Chiropractor and Nutritional Consultant. I also understand that this program and or treatment is not intended as medical advice or treatment and does not replace the need for medical treatment and/or advice from my physician. I have been advised to consult with my physician prior to starting the above supplementation and nutritional program.

Signature____