

# Welcome to LaBo Family Chiropractic



Date \_\_\_\_\_ Patient # \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Best time to call \_\_\_\_\_ AM \_\_\_\_\_ PM Email \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

SS# \_\_\_\_\_ Marital Status  M  S  W  D # of children \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Whom make we thank for referring you? \_\_\_\_\_

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Do you have health insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Name of Company \_\_\_\_\_

Name of subscriber \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Relationship to subscriber \_\_\_\_\_ Medicaid Yes \_\_\_\_\_ No \_\_\_\_\_ Medicare Yes \_\_\_\_\_ No \_\_\_\_\_

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Reason for visit? \_\_\_\_\_ When did your symptoms first appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Circle the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10

Type of pain:  Sharp  Dull  Throbbing  Numbness  Burning

Tingling  Cramps  Stiffness  Swelling  Other

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Is this condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of the accident?  Auto insurance  Employer  Work Comp

Attorney name (if applicable) \_\_\_\_\_

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What treatment have you already received for your condition (medical, surgery, physical therapy, chiropractic care)?

Name and address of other doctors who have treated you for this condition \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ Spinal Exam \_\_\_\_\_

Chest X-ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

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Mark an X on the picture where you have pain, numbness, or tingling.

How often do you have this pain? \_\_\_\_\_

What is the worst time of your day?  Morning  Afternoon  Evening

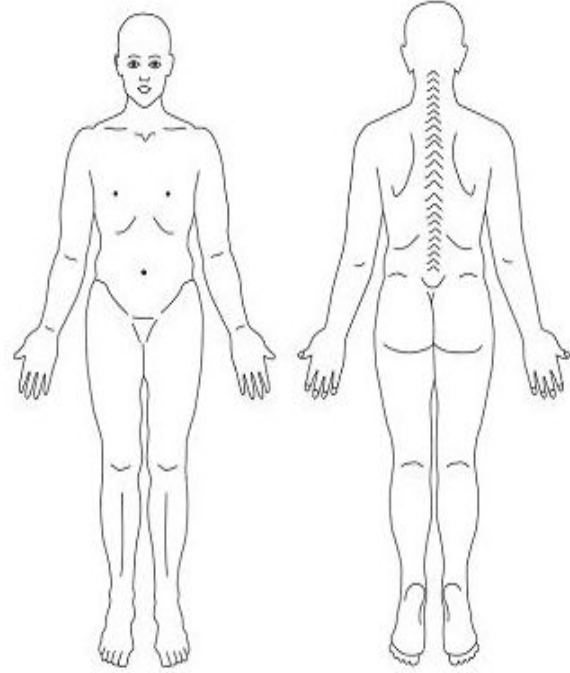
Is your pain  Constant  Frequent  Intermittent  Occasional

Does it interfere with your  Work  Sleep  Daily Routine

Activities or Movements that are painful to perform:

Sitting  Standing  Walking  Bending  Lying Down

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**EXERCISE**

- None
- Moderate
- Daily
- Heavy
- Water

**WORK ACTIVITY**

- Sitting
- Standing
- Light Labor
- Heavy Labor
- Glasses/Day \_\_\_\_\_

**HABITS**

- Smoking
- Alcohol
- Coffee/Caffeine
- High Stress Level

Pack/Day \_\_\_\_\_

Drinks/Week \_\_\_\_\_

Cup/Day \_\_\_\_\_

Reason \_\_\_\_\_

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Injuries/Surgeries you have had? \_\_\_\_\_

Broken Bones?  Yes  No Date: \_\_\_\_\_ Briefly Explain: \_\_\_\_\_

Been Hospitalized?  Yes  No Date: \_\_\_\_\_ Briefly Explain: \_\_\_\_\_

Had Surgery?  Yes  No Date: \_\_\_\_\_ Briefly Explain: \_\_\_\_\_

Had a Stroke?  Yes  No Date: \_\_\_\_\_ Briefly Explain: \_\_\_\_\_

Had Major Sprains/Strains?  Yes  No Date: \_\_\_\_\_ Briefly Explain: \_\_\_\_\_

Been Diagnosed with an Eating Disorder?  Yes  No Date: \_\_\_\_\_ Briefly Explain: \_\_\_\_\_

**Medications**

**Allergies**

**Vitamins/Herbs/Minerals**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Are you pregnant?     Yes     No      Due Date \_\_\_\_\_

**Pregnancy release (For all Females):**

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Please check to indicate if you have trouble with any of the following:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abdominal Pain          | <input type="checkbox"/> Dizziness/Lightheadedness      | <input type="checkbox"/> Multiple Sclerosis         |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Ear Infections                 | <input type="checkbox"/> Nausea or Vomiting         |
| <input type="checkbox"/> Anxiety/ Nervousness    | <input type="checkbox"/> Erectile Dysfunction           | <input type="checkbox"/> Night Sweats               |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Excessive Thirst               | <input type="checkbox"/> Prostate Trouble           |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Fainting                       | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Autoimmune Disease      | <input type="checkbox"/> Fatigue or Weakness            | <input type="checkbox"/> Ringing or Buzzing in Ears |
| <input type="checkbox"/> Bedwetting              | <input type="checkbox"/> Fertility Problems             | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Blood in Urine or Stool | <input type="checkbox"/> Fibromyalgia                   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Bone Fracture           | <input type="checkbox"/> Headaches                      | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heartburn                      | <input type="checkbox"/> Skin Problems              |
| <input type="checkbox"/> Chest Pain or Pressure  | <input type="checkbox"/> Hearing Trouble                | <input type="checkbox"/> Sleeping Problems          |
| <input type="checkbox"/> Chronic Cough           | <input type="checkbox"/> Heart Trouble                  | <input type="checkbox"/> Thyroid Trouble            |
| <input type="checkbox"/> Cold Hands or Feet      | <input type="checkbox"/> High/ Low Blood Pressure       | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Constipation/ Diarrhea  | <input type="checkbox"/> Kidney/ Bladder Trouble        | <input type="checkbox"/> Upset Stomach              |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Loss of Balance                | <input type="checkbox"/> Urinary Pain/ Frequency    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Loss of Memory                 | <input type="checkbox"/> Vertigo                    |
| <input type="checkbox"/> Difficulty Speaking     | <input type="checkbox"/> Loss of Smell/ Taste           | <input type="checkbox"/> Vision Trouble             |
| <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Mental or Emotional Difficulty | <input type="checkbox"/> Weight loss/gain           |
| <input type="checkbox"/> Dislocated Joints       | <input type="checkbox"/> Mood Swings/ Irritability      | <input type="checkbox"/> Other: _____               |

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By signing below, I am stating that all of the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date