Welcome to LaBo Family Chiropractic

Date ______________________ Patient # ___________________

Name ____ Date of Birth ______________Age __________ Sex: M F

Address ____ City ____________________ State _____Zip ____________

Phone (H) __________________________ (W) ____________________________ (C) ___________________________

Mobile Carrier (Verizon, AT&T, Sprint, etc) _____________ Email____

Occupation____ Employer ______________________________________

SS# ___________________________ Marital Status ❒ M ❒ S ❒ W ❒ D # of children ______________________

Spouse's Name ____ Employer ________________________________

Name of Emergency Contact _________________________ Relationship________________ Phone _______________

Whom may 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)?

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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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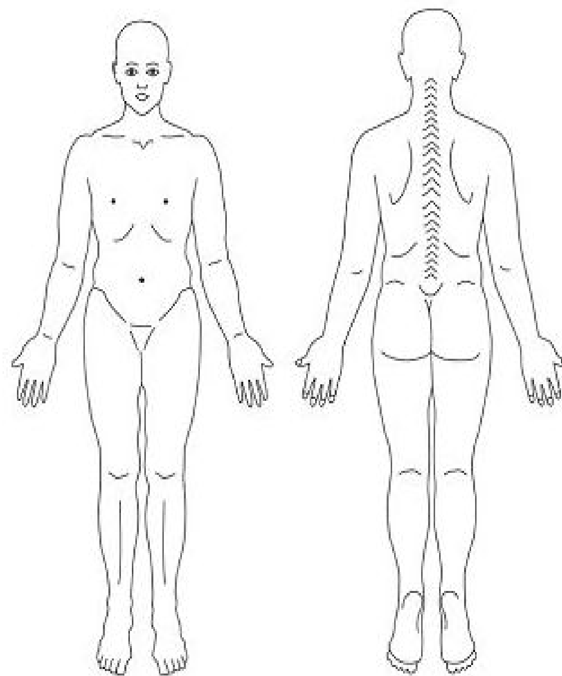

Mark an X on the picture where you have pain, numbness, or tingling.

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	WORK ACTIVITY	HABITS	
❒ None	❒ Sitting	❒ Smoking	Pack/Day _____________________
❒ Moderate	❒ Standing	❒ Alcohol	Drinks/Week___________________
❒ Daily	❒ Light Labor	❒ Coffee/Caffeine	Cup/Day ______________________
❒ Heavy	❒ Heavy Labor	❒ High Stress Level	Reason _______________________
❒ Water	Glasses/Day____________________		

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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 ____

<u>Pregnancy release (For all Females):</u>
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:

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

____ ____________________________
Staff Signature Date