Date________________

LaBelle Chiropractic
1152-B Haywood Road
Greenville, SC 29615

Reactivated/Updated Case History for Chiropractic Care

(Please Print Clearly)

Last Name		First Name			Middle I.
Home Address			Social Security Number		Sex M F
Home Phone ( )	Work Phone ( )	Cell Phone ( )	Date of Birth ___/___/________		Age
Occupation	Employer	Email Address		Marital Status M S D W	
Spouse's Name (or parent)		Number of Children	How did you hear about our office?		

After Childhood to Present

- ☐ Smoke
- ☐ Drink alcohol
- ☐ Eat unhealthy foods
- ☐ Little to no exercise
- ☐ Occupational stress
- ☐ Home stress
- ☐ Physical stress
- ☐ Computer (home or work)
- ☐ Sit at work mostly
- ☐ Stand at work mostly
- ☐ Stomach sleeper

Surgeries:____
____
#of Medications/day:____
What do you take medications for?
1)____________________________2)________________________________
3)____________________________4)________________________________
Sports/Hobbies:____
____
Car Accidents: ☐ Yes ☐ No *When*:________________________________
Briefly describe:____
Falls/Injuries:____________________________ *When*:_______________

Many times symptoms indicate a long standing spinal condition. Please check off any symptoms you have now or have experienced in the past.

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Difficulty Breathing
☐	☐	Ear Infections	☐	☐	Pain between the Shoulders
☐	☐	Fatigue	☐	☐	Asthma
☐	☐	Irritability	☐	☐	Frequent colds/flues
☐	☐	Depression	☐	☐	Ulcers
☐	☐	Neck Pain	☐	☐	Digestive problems
☐	☐	Dizziness	☐	☐	Diarrhea
☐	☐	Loss of Concentration	☐	☐	Constipation
☐	☐	Difficulty Sleeping	☐	☐	Back Pain
☐	☐	TMJ	☐	☐	Menstrual pain
☐	☐	Arm/hand pain or numbness	☐	☐	Leg/foot pain or numbness
☐	☐	Chest pain	☐	☐	Cancer
☐	☐	Heart Problems	☐	☐	Diabetes
☐	☐	Heartburn	☐	☐	Stroke

Please describe your symptoms or reasons for making this appointment:

____

How long have you had this condition?____

Have you had a similar condition in the past?____

What makes it worse?____

What relieves it? ____

Do you feel your symptoms have been getting: □ better □ same □ worse?

Is the pain: □ sharp □ dull □ burning □ tight □ throbbing □ numb?

Is this condition interfering with your: □ work □ home routine □ family?

What doctors have you seen about this condition?____

Have you seen a Chiropractor before? □ yes □ no Who?___________________________________

When? __________________________ Approximately how many visits?_______________________

Do you feel like you benefited from chiropractic care? ___________________________________

Present Primary Physician: ____

AUTHORIZATION TO ADMINISTER CARE

INIT_____ I authorize Dr. LaBelle, and whomever he may designate as his assistant, to administer treatment as is necessary. I also certify that no guarantee has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

INIT_____ I authorize the release of any medical information necessary to process my insurance claim and I also certify that all information given to this office is correct and complete.

X-RAY NOTE

INIT_____ The amount paid LaBelle Chiropractic Center for x-rays is for examination only. The x-ray negatives will remain property of this office, where they may be seen at any time as required by federal law.

FINANCIAL RESPONSIBILITY

INIT_____ I agree to be personally responsible for all charges I incur in this office. It is the policy of this office that all visits be paid in full at the time services are rendered unless other arrangements have been made.

Please choose the option that is best suited to your needs: □ Insurance □ Medicare □ Cash (no insurance)

I have read the information stated above and have answered everything to the best of my knowledge.

Signature:_______________________________________ Date:_____________________

Terms of Acceptance

Patient Name: ____________________

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and its nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the body to function properly and to heal itself.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and his only means is the correction of the vertebral subluxation.

Please understand that chiropractic is NOT a substitute for medical treatments of any kind. Also, No statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effects. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractors malpractice insurance costs less than his car insurance), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness. This is comparative to post exercise soreness. This typically subsides quickly. If you do experience any post adjustment sensations please tell the doctor on your next visit. If you have any questions concerning the safety of chiropractic in certain situations, please explain this to the doctor. The doctor will do his utmost to care for you in the safest and most effective manner, just as he would his own family.

I have read the above, understand it fully and undertake chiropractic care on this basis.

________________________________ ____________________

Signature Date

HIPAA - Health Insurance Portability & Accountability Act

The following is an explanation of our Privacy Policies for this office.

- Our office does NOT distribute or make available to any outside source your private personal health information.
- Your information is secure and is used only in submitting claims to third party carriers for payment of services.
- Our office is set up as an open adjusting environment.
- Our office may send you seasonal cards or birthday cards.
- Our office may call you to confirm or reschedule an appointment if necessary.
- A family member can be present when hearing the results of your exam and tests.

A more detailed explanation of our policies is available for you to read and take a copy with you. Please ask the front desk for it.

By signing, I have read, understand and agree to the privacy policies for this office. I can take a copy for my records. I understand that if I choose not to participate that I can and will notify the LaBelle Chiropractic Center staff of my concerns in writing.

________________________________ ____________________

Signature Date

Due to your current complaint, check off any activity that is restricted or more difficult for you to perform.
Then, circle the 3 that are most important to you.

I find it difficult to:

- ☐ Care for Family Members
- ☐ Carry Groceries
- ☐ Sleep or Lay down
- ☐ Climb Stairs
- ☐ Cook
- ☐ Care for pets
- ☐ Drive
- ☐ Sit for a long period
- ☐ Stand for a long period
- ☐ Sit at a Computer
- ☐ Do Household Chores
- ☐ Lift/Care for Children/Grandchildren
- ☐ Read
- ☐ Self Care: Bathing
- ☐ Self Care: Dressing
- ☐ Self Care: Shaving

It is difficult at work to:

- ☐ Change positions
- ☐ Extended Computer Use
- ☐ Perform my work duties

It is difficult to do my Hobbies:

- ☐ Gardening
- ☐ Yard Work
- ☐ Ceramics
- ☐ Crafts
- ☐ Scrapbooking
- ☐ Playing Musical Instrument
- ☐ Sewing
- ☐ Wood Working
- ☐ Other____________

Restricted from Sports:

- ☐ Basketball
- ☐ Baseball
- ☐ Football
- ☐ Golf
- ☐ Running
- ☐ Cycling
- ☐ Swimming
- ☐ Soccer
- ☐ Softball
- ☐ Tennis
- ☐ Volleyball
- ☐ Cheerleading
- ☐ Walking
- ☐ Horseback Riding
- ☐ Hiking
- ☐ Exercising
- ☐ Weight Lifting
- ☐ Attending Sporting Events
- ☐ Coaching Sports

Other activities I find it difficult to do:

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____

____

Patient Signature

____

Date