Date______________________

LaBelle Chiropractic Center
1152-B Haywood Road
Greenville, SC 29615

# Welcome to LaBelle Chiropractic

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. The information we collect on the following pages is really important for us to properly assess your symptoms, function, health care challenges and health care goals. Please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

**General Information** (Please Print Clearly)

Name___________________________________________ What should we call you?___________________

Street Address____________________________________________________________________________

City_________________________ State_____ Zip___________Social Security #_________________________

Cell Phone #________________ Home Phone #______________Email Address _________________________

Place of Employment__________________ Position_____________________Work Phone #_______________

Birth Date_____________Age_____ Male__ Female__ Marital Status: M S D W Number of Children_____

Spouse's Name (or parent)______________ Social Security #___________Work Phone #______________

Spouse's (or parent's) Place of Employment____________________________________________________

Who is your Primary Medical Doctor?____________________________________. We like to work together with our patients physicians. May we send them updates on your care in this office? ☐Yes ☐No

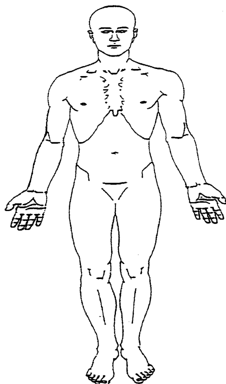
How were you referred to our office ?________________________________________________________

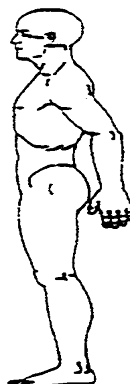
**Health Information-Present Problem**

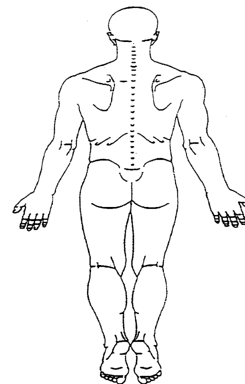
What is your major complaint?________________________________ For how long?_______________

*If you are seeing us for a pain related issue, USE THE SYMBOLS to show the type of pain you feel.*

| XXXXXXXXX | / / / / / / / / / / | o o o o o o o o o | s s s s s | - - - - - - - - |
|---|---|---|---|---|
| **DULL/ACHY** | **SHARP/STABBING** | **NUMBNESS/TINGLING** | **STIFF/TIGHT** | **BURNING** |







Using the pain scale below, CIRCLE the pain level you experience when your problem is at its very worst:

**0** = **No Pain**. No Discomfort
**1** = **Minimal Discomfort**. Minor stiffness or tightness.
**2** = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
**3** = **Minimal Pain**. More than just sore. Uncomfortable.
**4** = **Mild Pain**. Noticeable pain but tolerable.
**5** = **Moderate Pain**. Aggravating. Still allows movement.
**6** = **Strong Pain**. Quite aggravating. Movement slightly limited.
**7** = **Very Strong Pain**. Very aggravating. Movement definitely limited.
**8** = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
**9** = **Severe Pain**. Brings tears. Almost impossible to move.
**10** = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? ________________________________________________

Is there any numbness or tingling in the arms or legs? _______________________________________________

How often do you experience your problem? (Please indicate for each of the body location if applicable)

Constant (75 – 100% of the time)____________________________________________________________

Frequent (50 – 75% of the time) ____________________________________________________________

Occasional (25 – 50% of the time) ___________________________________________________________

Intermittent (0 – 25% of the time) ___________________________________________________________

Is this condition interfering with your: Work_____ Sleep_____ Daily Routine_____ Exercise_____

What does this condition prevent you from doing?_____________________________________________

Has this ever happened before?__________ When?____________________________________________

Was it as bad as this episode? _____Not as bad _____About the same ______Worse this time

What makes your problem **worse**? ☐Sitting ☐Standing ☐Changing Position ☐Walking ☐Bending ☐Lifting ☐Twisting ☐Reaching ☐Driving ☐Sleeping ☐Sneeze/Cough ☐Computer Work ☐Telephone ☐Going From Sit To Stand ☐Other________________________________________________________________________________

Other doctors consulted for this condition______________________________Results____________________

What tests have you already had for this problem? ☐X-rays ☐MRI ☐C.T. Scan ☐Myelogram ☐EMG/NCV ☐None ☐Other ____________________________________________________________________________

What have you already tried for this problem? ☐Ice ☐Heat ☐Anti-inflammatory ☐Pain Meds ☐Muscle Relaxers ☐Injections ☐Physical Therapy ☐Massage ☐Exercise ☐Other _____________________________

Have you had previous chiropractic care?______When?_____________By Whom?________________
Was this chiropractic treatment for your current complaint or another?__________________________

**Health Information-Present Health Condition**

Do you now or frequently suffer from any of the following?

| | | | | |
|---|---|---|---|---|
| __Headaches | __High Blood Pressure | __Arm/Elbow Pain | __Indigestion | __Leg or Hip Pain |
| __Nervousness | __Sore Throats | __Wrist Pain | __Hiatal Hernia | __Impotency |
| __Insomnia | __Neck Stiffness | __Wrist Pain | __Kidney Troubles | __Knee Pains |
| __Chronic Fatigue | __Shoulder Pain | __Arm Numbness | __Skin Conditions | __Low Back Pain |
| __Dizziness/Vertigo | __Upper Back Pain | __Carpal Tunnel | __Constipation | __Sciatica |
| __Nausea | __Chronic Colds | __Rapid Heart Rate | __Diarrhea | __Numbness in legs |
| __Sinus/ Allergies | __Thyroid Problems | __Liver Problems | __Gas | __Numbness in feet |
| __Depression | __Asthma | __High Cholesterol | __Stomach Cramps | __Poor Circulation |
| __TMJ Disorder | __Diabetes | __Stomach Troubles | __Bladder Troubles | __Hemorrhoids |

Women __PMS __Irregular Cycle __Painful Periods __Excessive Flow __Hot Flashes

Children __Ear Infections __Frequent Colds __Growing Pains __Bed wetting __Inverted Foot

MEDICATIONS & SUPPLEMENTS

List any medications, herbs or supplements you are taking and the reason for their use:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Do you take a multivitamin? ☐Yes ☐No Fish Oil? ☐Yes ☐No Probiotic? ☐Yes ☐No Vitamin D? ☐Yes ☐No

Occupational Activities

Please describe your job:__________________________________________________________

Which of the following activities does your job require you to do often? __Lifting __Pulling __Pushing __Twisting __Bending __Computer Use __Typing __Answering Telephone

Hobbies Sports__________________________ Home Activities__________________________

Outdoor Activities_________________________ Other_____________________________

On a scale of 0 to 10 with 0=Worst and 10=Best, rate how well you think you are doing with the following:

Exercise________ Sleep ________ Diet _________ Stress Level _______Energy Level__________

**Health Information-Past Health Condition**

Please list any significant conditions that you've been diagnosed with or been treated for in the past:

______________________________________________________________________________

______________________________________________________________________________

Please list any surgeries you have had in the past:

______________________________________________________________________________

______________________________________________________________________________

Have you been in an auto accident: __Lately __Past Year __Past Five Years __Over Five Years __Never
Please describe__________________________________________

**Health Information-Family History**

Mother: ☐Living ☐Deceased List any medical problems: ___________________________________________

Father: ☐Living ☐Deceased List any medical problems: ___________________________________________

List any problems common in your family: ☐Cancer ☐Diabetes ☐Heart disease ☐High blood pressure ☐Stroke ☐Arthritis ☐Scoliosis ☐Thyroid disease ☐Osteoporosis _______________________________________________

***INSURANCE INFORMATION:***

*Even if you are here through a non-referral source such as an external workshop, we are happy to verify your insurance coverage. We will NEVER bill your insurance without your permission. It means we will verify your benefits and have that information prepared for you. Thank you for providing.*

Who is responsible for this account? ____________________ Relationship to patient:____________________

Insurance Co:_____________________________________ID#______________________________________

**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 or assurance 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_____ I hereby give my consent to and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant.

**FINANCIAL RESPONSIBILITY**

INIT_____ I agree to be personally responsible for all charges I incur in this office.

**Payment Information**

*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:
__ CASH-You either do not have insurance or your insurance does not cover chiropractic.
__ INSURANCE-Please give your insurance card to the front desk so that we may keep a copy on file.
__ MEDICARE-Please give your Medicare card to the front desk. We will file your claims on your behalf.

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

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**

## TODAY ONLY:

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
- ☐ Do Household Chores
- ☐ Lift/Care for Children/Grands
- ☐ Read
- ☐ Self Care: Bath/Dress/Shave

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
- ☐ Crafts
- ☐ Scrapbooking
- ☐ Playing Musical Instrument
- ☐ Sewing
- ☐ Wood Working
- ☐ Other___________

Restricted from Sports:
- ☐ Basketball
- ☐ Baseball
- ☐ Football
- ☐ Golf
- ☐ Running
- ☐ Cycling
- ☐ Swimming
- ☐ Soccer
- ☐ Tennis
- ☐ Volleyball
- ☐ Walking/ Hiking
- ☐ Exercising/Weight Lifting
- ☐ Attending Sporting Events
- ☐ Coaching Sports

Other activities I find it difficult to do:

____________________________
____________________________
___________________________

______________________________

Name Date

## PROGRESS EXAM 1:

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
- ☐ Do Household Chores
- ☐ Lift/Care for Children/Grands
- ☐ Read
- ☐ Self Care: Bath/Dress/Shave

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
- ☐ Crafts
- ☐ Scrapbooking
- ☐ Playing Musical Instrument
- ☐ Sewing
- ☐ Wood Working
- ☐ Other___________

Restricted from Sports:
- ☐ Basketball
- ☐ Baseball
- ☐ Football
- ☐ Golf
- ☐ Running
- ☐ Cycling
- ☐ Swimming
- ☐ Soccer
- ☐ Tennis
- ☐ Volleyball
- ☐ Walking/ Hiking
- ☐ Exercising/Weight Lifting
- ☐ Attending Sporting Events
- ☐ Coaching Sports

Other activities I find it difficult to do:

____________________________
____________________________
___________________________

______________________________

Name Date

## PROGRESS EXAM 2:

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
- ☐ Do Household Chores
- ☐ Lift/Care for Children/Grands
- ☐ Read
- ☐ Self Care: Bath/Dress/Shave

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
- ☐ Crafts
- ☐ Scrapbooking
- ☐ Playing Musical Instrument
- ☐ Sewing
- ☐ Wood Working
- ☐ Other___________

Restricted from Sports:
- ☐ Basketball
- ☐ Baseball
- ☐ Football
- ☐ Golf
- ☐ Running
- ☐ Cycling
- ☐ Swimming
- ☐ Soccer
- ☐ Tennis
- ☐ Volleyball
- ☐ Walking/ Hiking
- ☐ Exercising/Weight Lifting
- ☐ Attending Sporting Events
- ☐ Coaching Sports

Other activities I find it difficult to do:

____________________________
____________________________
___________________________

______________________________

Name Date

## REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days: 0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

| **Head:**<br>______ Headaches<br>______ Faintness<br>______ Dizziness<br>______ Insomnia | **Energy/Activity:**<br>_____ Fatigue/Sluggishness<br>_____ Apapthy/Lethargy<br>_____ Hyperactivity<br>_____ Restlessness | **Lungs:**<br>_____ Chest Congestion<br>_____ Asthma, Bronchitis<br>_____ Shortness Of Breath<br>_____ Difficulty Breathing |
|---|---|---|
| **Eyes:**<br>_____ Watery or Itchy Eyes<br>_____ Swollen, Red or Sticky Eyelids<br>_____ Bags or Dark Circles Under Eyes<br>_____ Blurred or Tunnel Vision (not including near or far sightedness) | **Weight:**<br>_____ Binge Eating/Drinking<br>_____ Craving Certain Foods<br>_____ Excessive Weight<br>_____ Compulsive Eating<br>_____ Water Retention<br>_____ Underweight | **Heart:**<br>_____ Irregular or Skipped Heartbeat<br>_____ Rapid or Pounding Heartbeat<br>_____ Chest Pain |
| **Ears:**<br>_____ Itchy Ears<br>_____ Earaches, Ear Infections<br>_____ Drainage From Ear<br>_____ Ringing In Ears, Hearing Loss | **Emotions:**<br>_____ Mood Swings<br>_____ Anxiety/Fear/Nervousness<br>_____ Anger/Irritability/Aggressiveness<br>_____ Depression | **Digestive Tract:**<br>______ Nausea, Vomiting<br>______ Diarrhea<br>______ Constipation<br>______ Bloated Feeling<br>______ Belching, Passing Gas<br>______ Heartburn<br>______ Intestinal/Stomach Pain |
| **Nose:**<br>_____ Stuffy Nose<br>_____ Sinus Problems<br>_____ Hay Fever<br>_____ Sneezing Attacks<br>_____ Excessive Mucus Formation | **Mind:**<br>_____ Poor Memory<br>_____ Confusion, Poor Comprehension<br>_____ Poor Concentration<br>_____ Poor Physical Condition<br>_____ Difficulty Making Decisions<br>_____ Stuttering or Stammering<br>_____ Slurred speech | |
| **Mouth & Throat:**<br>_____ Chronic Coughing<br>_____ Frequent Need to Clear Throat<br>_____ Sore Throat, Hoarseness<br>_____ Swollen or Discolored Tongue<br>_____ Canker Sores | | **Other:**<br>______ Frequent Illness<br>______ Frequent or Urgent Urination<br>______ Genital Itch or Discharge |
| **Skin:**<br>_____ Acne<br>_____ Hives, Rashes, Dry Skin<br>_____ Hair Loss<br>_____ Flushing, Hot Flashes<br>_____ Excessive Sweating | **Joints/Muscles:**<br>_____ Pain or Aches in Joints<br>_____ Arthritis<br>_____ Stiffness or Limited Movement<br>_____ Pain or Aches in Muscles<br>_____ Weakness or Fatigued Muscles | **Grand Total:** |

## HIPAA - Health Insurance Portability and Accountability Act

LaBelle Chiropractic Center
1152 B Haywood Road
Greenville, SC 29615
(864) 234-5678

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 LaBelle Chiropractic Center staff of my concerns in writing.

Patient Signature____________________________________Date_____________