

# Labrecque Family Chiropractic PC

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**WELCOME TO OUR OFFICE. YOU ARE SPECIAL AND WE THANK YOU FOR YOUR TRUST!**

(Please print using black or blue ink. If there is something that does not apply to you please put N/A on the line.)

## Section 1: Patient Information

Referred By: \_\_\_\_\_

Name (first, middle, last): \_\_\_\_\_

Preferred Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

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

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status:  Married  Single  Divorced  Widow

Name of Spouse/Significant Other: \_\_\_\_\_ Name & Ages of Children: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

## Section 2: History of Complaint

Primary Complaint(s): \_\_\_\_\_

Secondary Complaint(s): \_\_\_\_\_

Are your complaints due to an Accident?  YES  NO If yes, what type?  Work  Auto  Personal

Date of Accident \_\_\_\_\_ If Work or Auto accident, have you reported this accident to anyone?  Yes  No

Who was it reported To? \_\_\_\_\_ Have you seen any doctors for this condition:  YES  NO

Please list the doctor specialty, & for how long you were seen. \_\_\_\_\_

List any medications you currently take. (Prescription and non-prescription) \_\_\_\_\_

If you take medication for these complaints do you think it's effective in eliminating your condition?  YES  NO

If YES then how? \_\_\_\_\_

If these complaints are left alone & continue to get worse, how do you think that will affect you? \_\_\_\_\_

## Section 3: Past Medical History: Please list What, When, and Any Results.

Surgeries: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Major Illness: \_\_\_\_\_

## Section 4: Chiropractic History

Have you ever seen a Chiropractor before?  Yes  No When \_\_\_/\_\_\_/\_\_\_

Name of Doctor: \_\_\_\_\_ For what reason were you seen? \_\_\_\_\_

Were you helped?  YES  NO Why are you changing chiropractors? \_\_\_\_\_

What spinal maintenance programs were you given to maximize the stability of your spine & Nervous System?

(If none was given, please write N/A) \_\_\_\_\_

Did you follow the spinal maintenance program?  YES  NO If no, why not? \_\_\_\_\_

Name \_\_\_\_\_

DOB \_\_\_\_\_

**Section 5: Past Trauma History:** Starting from birth, we all experience thousands of physical, mental, & chemical stresses. These stresses can cause *Postural Distortions* (misalignments of the spine) and lead to our current health problems.

Please write down some of the falls, injuries, & traumas that you've experienced. (Please put NA if it doesn't apply to you)

**A. Car Accidents** (List even minor ones. A 5mph crash from a 3000lb vehicle can cause damage to your spine even if you didn't *feel* injured!)

Example Date 12-1-2007 Type of Collision:  Front  Side  Rear Speed 10 mph Injuries Neck Whiplash

Date \_\_\_\_\_ Type of Collision:  Front  Side  Rear Speed \_\_\_\_\_ Injuries \_\_\_\_\_

Date \_\_\_\_\_ Type of Collision:  Front  Side  Rear Speed \_\_\_\_\_ Injuries \_\_\_\_\_

Date \_\_\_\_\_ Type of Collision:  Front  Side  Rear Speed \_\_\_\_\_ Injuries \_\_\_\_\_

**B. Sports Injuries** (if there are too many to list please write the name of the sport and "MANY" next to it.)

Example Date 1-1-2008 Type of Sport Basketball Type of Injury Sprained Right Knee

Date \_\_\_\_\_ Type of Sport \_\_\_\_\_ Type of Injury \_\_\_\_\_

Date \_\_\_\_\_ Type of Sport \_\_\_\_\_ Type of Injury \_\_\_\_\_

Date \_\_\_\_\_ Type of Sport \_\_\_\_\_ Type of Injury \_\_\_\_\_

**C. Slips, falls, & Bike Accidents** (We understand there may have been a lot of slips & falls since birth, so please list the major ones.)

Example Date 2-1-2008 Type of Injury Slipped on ice & bruised Left Elbow

Date \_\_\_\_\_ Type of Injury \_\_\_\_\_

Date \_\_\_\_\_ Type of Injury \_\_\_\_\_

**D. Repetitive Injuries** (Please list all repetitive injuries you've had in the past.)

Example: Date 3-1-2008 Type of Injury Lifting boxes injured lower back

Date \_\_\_\_\_ Type of Injury \_\_\_\_\_

Date \_\_\_\_\_ Type of Injury \_\_\_\_\_

Date \_\_\_\_\_ Type of Injury \_\_\_\_\_

**Section 6: Health Goals**

What are your personal health goals?  Achive Health  Reduce/Eliminate Pain  Other: \_\_\_\_\_

How do you want us to handle your problem(s) / What are your expectations of this office? Please check below:

- Temporary Relief (mask/help the symptom, but do not fix the cause of the problem)
- Maximum Correction (find & correct the cause of the problem for maximum stability in the future)
- Other: \_\_\_\_\_

Please rate the following on a scale of 1-10 (10 being the **MOST**, and 1 being the **LEAST**):

- \_\_\_\_ How committed are you to being at your maximum health potential?
- \_\_\_\_ How important is it for your family to be at their optimum health potential?
- \_\_\_\_ How committed are you to preventing degenerative arthritis, diseases, or other conditions?

What are your favorite hobbies or activities to do now? \_\_\_\_\_

What activities are you looking forward to doing in retirement? \_\_\_\_\_

I acknowledge that I have read Labrecque Family Chiropractic's Privacy Practices for Protected Health Information Form.

I acknowledge that I have read Labrecque Family Chiropractic's X-ray Consent, X-ray Minor Consent and Pregnancy release and consent to chiropractic spinal X-rays.

Patient or Guardian's Signature: \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

**Section 7: Present and Past Conditions**

Using the codes listed below, please fill in EVERY blank with the applicable letter. **Check** to indicate if you have Pain or Stiffness and on which side of the body. **If both sides apply, please check BOTH boxes.**

**P** = Past Medical Condition      **C** = Current Medical Condition      **N** = Never had this Medical Condition

**Example:** C Shoulder  Pain  Stiff  R  L

Extremities	Location	Respiratory	Other Conditions	Male
___ Hip <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ Asthma	___ Headaches / Migraines	___ Impotence
___ Knee <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ Chest Pain	___ Trouble Sleeping	___ Prostate Problems
___ Foot <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ Difficulty Breathing	___ Excessive Sweating	<b>Female</b>
___ Shoulder <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ Lung Problems	___ Cancer & Type: _____	___ Menopausal Problem
___ Elbow <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ COPD	___ Emotional / Mental Disorders	___ Menstrual Cycle Problems
___ Wrist <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<b>Digestion</b>	___ Learning Disability	
___ Jaw Pain <input type="checkbox"/> Click <input type="checkbox"/> Pop	<input type="checkbox"/> R <input type="checkbox"/> L	___ Heartburn	___ Nervous / Irritable	
___ Swollen or Painful Joints		___ Digestion Problems	___ Loss of Memory	<b>Social History</b>
<b>Spine</b>		___ Gallbladder Problems	___ Dizziness / Loss of Balance	___ Smoking
___ Head / Shoulders Feel Heavy / Tired		___ Colon Trouble	___ Arthritis	How much _____
___ Neck <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ Diarrhea / Constipation	___ Epilepsy / Convulsions	How Often _____
___ Upper Back <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ Hemorrhoids	___ Knocked Unconscious	
___ Mid Back <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	<b>Immune System</b>	___ Frequent Ear Infections	___ Alcoholic Beverage Consumption
___ Low Back <input type="checkbox"/> Pain <input type="checkbox"/> Stiff	<input type="checkbox"/> R <input type="checkbox"/> L	___ Skin Problems	___ Ringing in Ear R / L	Occurs _____
___ Pain with cough, sneeze, or strain with bowel movement LOCATION of Pain: _____		___ Sinus Problems/ Allergies	___ Hearing Loss R / L	___ Recreational Drugs
Other: _____		___ Frequent Colds / Flu	___ Trouble Concentrating	What Used _____
		___ Anemia	___ AIDS / HIV	How Often _____
		___ Other: _____	___ Fracture / Dislocation of Bones: _____	___ Exercise Type _____
<b>Numbness / Tingling or Pain In:</b>		<b>Organ Problems or Dysfunction</b>	___ Other: _____	How Often _____
___ Arm <input type="checkbox"/> R <input type="checkbox"/> L		___ Diabetes	<b>Urinary Tract</b>	
___ Hand /Fingers <input type="checkbox"/> R <input type="checkbox"/> L		___ Liver Trouble	___ Kidney Trouble	
___ Legs <input type="checkbox"/> R <input type="checkbox"/> L		___ Hepatitis	___ Frequent Urination	
___ Foot / Toes <input type="checkbox"/> R <input type="checkbox"/> L		___ High/Low Blood Pressure	___ Bedwetting	
		___ Heart	___ Other: _____	

**Section 8: My Current Conditions are Affecting These Activities:**

Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Working Out	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Doing Home Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Working / Job	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform
Computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful	<input type="checkbox"/> Limits	<input type="checkbox"/> Unable to Perform

Which of the above conditions are increasing in Intensity & Frequency?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_

Doctor's Notes:

Are you Irritable as a result of these Conditions?  Yes  No If yes, Please Explain: \_\_\_\_\_

Do these conditions make you feel older?  Yes  No If yes, Please Explain: \_\_\_\_\_