LaDue Family Chiropractic
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PLEASE NOTE:
This file must be saved to your desktop before and after completing!

PATIENT INFORMATION

Date ______________ First Name __________________ Middle Name ___________ Last Name ________________

SSN __________________ Sex ____________ Birth Date ______________ Height ______ Weight _____________

Marital Status _________________ Spouse Name __________________________________ Number of Children ______

Address ___________________________________ City ______________________ State _______ Zip __________

Home Phone _____________________________________ Cell Phone ____

Email ____ Emergency Contact ____________________________________

Emergency Relation ________________________________ Emergency Phone _____________________________________

REFERRAL INFORMATION

I was referred by ____

How did you hear about the clinic?

☐ Advertisement ☐ Newspaper ☐ Community Event ☐ Provider Talk ☐ Family/Friend ☐ Other ________________

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company Name ____ Plan Name ___________________________

Phone # ________________ Primary ID/Policy __________________________ Primary Group # _______________

Policy Holder's Name ________________________ Policy Holder's DOB ____________________________________

If you are NOT the Policy Holder, what is your relation to the Policy Holder? ____________________________

For verification puposes, what is the Policy Holder's Social Security Number? ____________________________

Secondary Insurance Information

Insurance Company Name ____ Plan Name ___________________________

Phone # ________________ Secondary ID/Policy ________________________ Secondary Group # _____________

Policy Holder's Name ________________________ Policy Holder's DOB ____________________________________

If you are NOT the Policy Holder, what is your relation to the Policy Holder? ____________________________

For verification puposes, what is the Policy Holder's Social Security Number? ____________________________

EMPLOYER INFORMATION

Employed? ○ Yes ○ No Employer Name ____________________

Occupation ____________________

REASON FOR VISIT

Describe in your own words why you wanted to come for an appointment today:

PERSONAL HEALTH INFORMATION

Complaints/Concerns

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
E.g. Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

When was the last time you felt well? ____________________

Did something trigger your health changes?

Sleep

Average number of hours you sleep? __________ Do you have trouble falling asleep? ○ Yes ○ No

Do you feel rested upon awakening? ○ Yes ○ No Do you have problems with insomnia? ○ Yes ○ No

Do you snore? ○ Yes ○ No Do you use sleeping aids? ○ Yes ○ No Explain: ____________________

Injuries

Describe your injury and pain:

Pain level on scale of 1 - 10 (10 is excruciating pain) At its best? _________ At its worst? __________ Now? ___________

Type of injury ____

How did it occur? ☐ Work ☐ Automobile ☐ Fall ☐ Other ______________________

Injury Date ______________________ Have you missed work related to this injury? ○ Yes ○ No

Unable to work from (dates) ______________ to ______________

Received other treatment for this? ○ Yes ○ No Where or by whom? ______________________

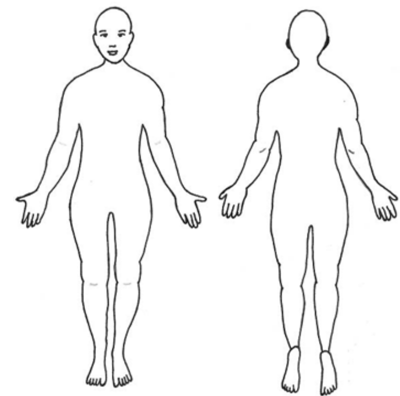
X-rays taken? ○ Yes ○ No Do you currently receive chiropractic care? ○ Yes ○ No

What clinic or chiropractor provides that care? ______________________

Please check the character of your current pain (you may check more than one):

Sharp Stabbing Dull Aching Soreness Stiffness Weakness

Throbbing Numbness Shooting Burning Tingling



Please rate the degree of you pain between 0-10, 0 being no pain and 10 being unbearable: ______

How often are your symptoms present?

Constant Frequent Occasional Intermittent

Since your problem began, is the pain? Increasing Decreasing No Change

What activities make symptoms BETTER? Sitting Standing Laying Down

Movement/Exercise Sleep/Rest Other(describe) ______________________

What activities make symptoms WORSE? Sitting Standing Coughing/Sneezing

Movement/Exercise Sleep/Rest Other(describe) ______________________

Tobacco/Alcohol

Currently using tobacco? ○ Yes ○ No How many years? _____ Packs per day _____

If yes, what type? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Previous smoking? How many years? _____ Packs per day _____ Are you exposed to 2nd hand smoke? ○ Yes ○ No

If yes, explain: ____

How many drinks currently per week? (1 drink=5 oz. wine, 12 oz. beer, and/or 1.5 oz. spirits)

☐ None ☐ 1 to 3 ☐ 4 to 6 ☐ 7 to 10 ☐ More than 10

Previous alcohol intake? ○ Yes ○ No If yes, was it: ○ Mild ○ Moderate ○ High

Allergies

I am allergic to the following medications:

I am allergic to the following foods or supplements:

Please list your symptoms/reactions to the above medications and/or foods:

Medications and Supplements

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals, and other nutritional supplements that you are currently taking.

Supplement Name	Dosage

Health History

Have you ever had any of the following:

Illnesses	Yes	No
Chicken Pox		
Measles		
Mumps		
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions		
Gallstones		
Gout		
Heart attack/Angina		
Heart failure		
Hepatitis		
High Blood Pressure		
Irritable bowel		
Kidney stones		
Mononucleosis		
Pneumonia		
Rheumatic fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Other (describe)		
Injuries	**Yes**	**No**
Head Injury		
Neck Injury		
Back Injury		
Fracture		
Other (describe)		

Diagnostic Studies	Yes	No	Date Performed
Chest X-ray			
Mammogram			
EKG			
Colonoscopy			
Upper GI Series			
Barium Enema			
CAT scan of abdomen			
CAT scan of brain			
CAT scan of spine			
Liver scan			
Bone scan			
Neck X-rays			
Back X-rays			
MRI			
Bone Density Test			
Blood Tests			
Other (describe)			

Operations	Yes	No
Tonsillectomy		
Tubes in Ears		
Appendectomy		
Gall Bladder		
Hernia		
Hysterectomy		
Dental Surgery		
Other (describe)		

Hospitalizations	
When	**For What Reason**

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

<u>Please mark P</u> <u>for in the</u> **<u>Past, C</u>** <u>for</u> **<u>Currently</u>** <u>have and</u> **<u>N</u>** <u>for</u> **<u>Never</u>**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:____

____

____

Women Specific

Check the box if yes and provide number.

☐ Pregnancies _____ ☐ Miscarriage _____ ☐ Living Children _____ ☐ Abortion _____ ☐ Cesarean _____

☐ Vaginal Delivery _____ ☐ Postpartum Depression _____ ☐ Toxemia _____ ☐ Baby Over 8 Pounds _____

☐ Gestational Diabetes _____

Menstrual History

Age At 1st Period _____ Menses Frequency ______________________ Length ________________________________

Painful? ○ Yes ○ No Clotting? ○ Yes ○ No Have you ever missed your period? ○ Yes ○ No

For how long? _______________________ Are you menopausal? ○ Yes ○ No Age At Menopause ______

Last Menstrual Period ________________________________

Do you take any hormone contraception? ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to LaDue Family Chiropractic. I authorize LaDue Family Chiropractic and its staff to examine and treat my condition as the practitioners see fit. I hereby authorize LaDue Family Chiropractic to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a **72 business hour cancellation policy** for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A $25 fee will be applied to all NSF checks. By clicking the submit button below, I agree to the financial policy described above and will adhere to all of its practices.

Please email this completed form to **cary@thewellnessway.com**

By typing or signing your name below on the signature line, you are agreeing to all of the paragraph above.

____

Signature Date

Thank you!