

NAME: _____

PT FILE #: _____

DATE: _____ Date of Birth: _____

Le Bel Chiropractic, LLC

Welcome to Our Office

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity for improved health potential and wellness services in the future. On

a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHILDHOOD YEARS (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	Unsure		YES	NO	Unsure
Did you have any childhood diseases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or inhalers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take or use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you under chiropractic care as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you fallen or jumped from a height greater than three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

YOUR ADULT YEARS (age 18 to present)

Do you now or did you ever smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	For how many years? _____ How much? ___ packs/day When did you quit? _____
Do you now or did you ever drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, do you drink daily, weekly, occasionally, or rarely? _____
Have you been in any accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____ _____
Have you had any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____ _____
Have you played sports as an adult?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____ _____
Participated in "extreme" sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____ _____
Do you take any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____ _____

Addressing The Issues That Bring You To This Office

If you have no symptoms or complaints, and are here for *Wellness Services*, please check here and skip to *Health History Profile* section below. Those experiencing a problem should fill out the following section describing your problem, including the effect it has had on your daily life.

Describe your problem(s): _____

When did it begin? _____ Is it due to an accident? Yes No

What caused it to start? _____

If you are experiencing pain, is it... Sharp Dull Aching Throbbing Numbness
 Tingling Burning Shooting Other: _____

Frequency of pain: Constant Comes & goes Daily Varies

What makes the problem worse: _____

What makes you feel better: _____

Does it interfere with: Work Sleep Walking Sitting Standing Home activities

What treatments have you tried for this problem? _____

Other doctors you have seen for this problem (please list): _____

Health History Profile

Please circle the number that relates to the symptoms listed below, even if they do not relate to your current problem.

0 = Never 1 = Occasional/Mild 2 = Often/Moderate 3 = Constant/Severe

Headaches..... 0 1 2 3	Bleeding gums..... 0 1 2 3	Itchy skin..... 0 1 2 3
Eyes painful..... 0 1 2 3	Coated tongue..... 0 1 2 3	Hot/cold spells..... 0 1 2 3
Blurry vision..... 0 1 2 3	Between meal snacks..... 0 1 2 3	Pressure/pain in head..... 0 1 2 3
Ringing in ears..... 0 1 2 3	Eat in a hurry..... 0 1 2 3	Dizziness..... 0 1 2 3
Frequent throat clearing... 0 1 2 3	Indigestion..... 0 1 2 3	Faintness..... 0 1 2 3
Nasal congestion..... 0 1 2 3	Upset stomach..... 0 1 2 3	Numbness/tingling..... 0 1 2 3
Constant runny nose..... 0 1 2 3	Belching or gas 0 1 2 3	Twitching..... 0 1 2 3
Frequent colds..... 0 1 2 3	Constipation..... 0 1 2 3	Epilepsy/seizures 0 1 2 3
Seasonal allergies..... 0 1 2 3	Diarrhea..... 0 1 2 3	Sleep walking..... 0 1 2 3
Asthma..... 0 1 2 3	Stomach ulcers..... 0 1 2 3	Bed wetting..... 0 1 2 3
Night sweats..... 0 1 2 3	Hemorrhoids..... 0 1 2 3	Frequent urination..... 0 1 2 3
Chest discomfort..... 0 1 2 3	Jaundice..... 0 1 2 3	Burning on urination..... 0 1 2 3
Chest pains..... 0 1 2 3	Liver/Gall bladder..... 0 1 2 3	Lose bladder control 0 1 2 3
High blood pressure..... 0 1 2 3	Painful joints..... 0 1 2 3	Fatigued/tired..... 0 1 2 3
Low blood pressure..... 0 1 2 3	Muscle aches..... 0 1 2 3	Wake up tired..... 0 1 2 3
Heart palpitations..... 0 1 2 3	Pain in arms or legs 0 1 2 3	Anxious/nervous..... 0 1 2 3
Difficulty breathing 0 1 2 3	Arthritis..... 0 1 2 3	Irritable..... 0 1 2 3
Out of breath easily..... 0 1 2 3	Sensitive/tender skin..... 0 1 2 3	Depression 0 1 2 3
Swollen ankles..... 0 1 2 3	Slow healing cuts..... 0 1 2 3	Stressed..... 0 1 2 3
Cold hands/feet..... 0 1 2 3	Bruise easily..... 0 1 2 3	Trouble sleeping..... 0 1 2 3
Leg cramps..... 0 1 2 3	Rashes/boils..... 0 1 2 3	Worry about your health 0 1 2 3

Have you ever been diagnosed with:

Cancer Yes No

Stroke Yes No

Lupus Yes No

Diabetes Yes No

Lung Disease Yes No

Immune Disease Yes No

Heart Problems Yes No

Kidney Disease Yes No

Other Disease Yes No

Patient Name: _____

Date _____