Hellenbrand Rabideaux Chiropractic

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Personal Information

NAME: ____________________ D.O.B.: ____________ AGE: ____ DATE: ____________

ADDRESS: ____

CITY.STATE/ZIP: ____

PHONE #: ____________ CELL #: ____________ WORK #: ____________

EMAIL ADDRESS: ____________________ MALE FEMALE

OCCUPATION: ____________________ EMPLOYERS NAME: ____________________

MARITAL STATUS: Single___ Married____ Divorced____ Widowed_____ SPOUSE: ____________

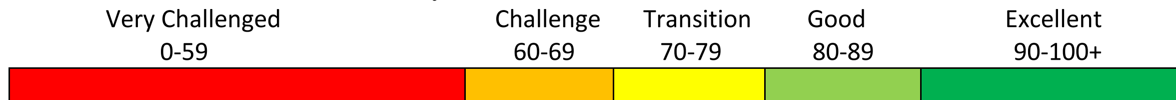
CHILDREN: Yes No IF YES, NAMES AND AGES: ____________________

WHO MAY WE THANK FOR REFFERING YOU TO OUR OFFICE? ____________________

Current Health Information

This form is very important to us. First it will allow us to address the issues that brought you into this office. Second, it will allow us to offer you the opportunity to improve your overall health and wellness for the future. By filling out this form thoroughly, it will give us a better understanding of the level of stress you are experiencing in your daily life. Each one of us experiences physical, chemical and emotional stress every day. These stresses can accumulate and deteriorate our health gradually over time. This form will allow us to better assess your current health as well as the challenges keeping your from reaching your full health potential.

Place an "**X**" where you think you are on this scale right now?
Place an "**O**" on the scale where you would like to be.



What brought you into the office? If you have no symptoms and are here for wellness chiropractic services, indicate wellness below.

Health concern:	Severity: 1-10 1=mild 10=extreme	When did it start?	Is the symptom constant or intermittent?
1. ____________	____________	____________	____________
2. ____________	____________	____________	____________
3. ____________	____________	____________	____________
4. ____________	____________	____________	____________
5. ____________	____________	____________	____________

If you are experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing

Does your pain radiate or travel anywhere: ☐ No ☐ Yes – please describe

____

____

Has this problem been getting: ☐ Worse ☐ Better ☐ Staying the same

Does anything make you feel worse? ______________________________

____

Does anything make you feel better? ______________________________

____

Have you tried anything to make you feel better that was of no help? __________

____

Is this condition effected your: ☐ Work ☐ Sleep ☐ Exercise ☐ Recreational Activities

☐ Mood ☐ Family life ☐ Other: ______________________________

Have you ever seen a chiropractor before? ☐ No ☐ Yes – if yes:

Name: ______________________ Date of last treatment: __________

Have you seen anyone else for this condition? ☐ Chiropractor ☐ Medical Doctor

Name: ______________________ Date: __________

What was done? ______________________________

What was the diagnosis? ______________________________

Name: ______________________ Date: __________

What was done? ______________________________

What was the diagnosis? ______________________________

Is there any chance you might be pregnant? ☐ No ☐ Yes Date of last period:__________

General Health Information

List any medications you are taking and why: (prescription and non-prescription)

____

____

____

List any allergies you have: ______________________________

Please check all symptoms you have experienced, even if they do not seem related to your current condition:

☐ Headaches	☐ Pain in neck	☐ Numbness in fingers	☐ Diarrhea
☐ Dizziness	☐ Stiffness in neck	☐ Numbness in toes	☐ Constipation
☐ Loss of balance	☐ Pain in back	☐ Tingling in fingers	☐ Urinary problems
☐ Blurry vision	☐ Stiffness in back	☐ Tingling in toes	☐ Cold Sweats
☐ Fainting	☐ Fatigue	☐ Cold hands	☐ Mood swings
☐ Light Sensitivity	☐ Sleeping problems	☐ Cold feet	☐ Depression
☐ Tension	☐ Upset stomach	☐ Heart Burn	☐ Ulcers
☐ Fever	☐ Irritability	☐ Menstrual pain	☐ Menstrual irregularity

Have you had any surgeries:

1. Type: ______________________________ Date ____________
2. Type: ______________________________ Date ____________
3. Type: ______________________________ Date ____________
4. Type: ______________________________ Date ____________
5. Type: ______________________________ Date ____________

Have you been in any accidents or injuries: (auto, work, other)

1. Type: ______________________________ Date ____________
2. Type: ______________________________ Date ____________
3. Type: ______________________________ Date ____________
4. Type: ______________________________ Date ____________
5. Type: ______________________________ Date ____________

Have you had x-rays taken? If yes, When ______________ Where ______________

What area of the body ______________________________

Please check yes or no:			
	Do you smoke?	☐ Yes	☐ No
	Did you smoke?	☐ Yes	☐ No
	Do you drink alcohol more than socially?	☐ Yes	☐ No
	Have you been in any accidents?	☐ Yes	☐ No
	Have you had any surgeries?	☐ Yes	☐ No
	Do you play any sports?	☐ Yes	☐ No
	Do you exercise regularly?	☐ Yes	☐ No

Please list your top three stresses in each area:

Physical stress (falls, accidents, posture, etc.)

1. ______________________________
2. ______________________________
3. ______________________________

Chemical stress (smoking, drinking, unhealthy foods, drugs, etc.)

1. ______________________________
2. ______________________________
3. ______________________________

Emotional stress (work, financial, relationships, etc.)

1. ______________________________
2. ______________________________
3. ______________________________

On a scale of 1-10 (1=very poor 10=very good), please rate your:

Eating habits: __________ Exercise habits: __________ Sleep habits: __________

Family Health Information

In our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list their names and any health conditions or concerns they might have:

Children: ______________________________

Spouse: ______________________________

Mother: ______________________________

Father: ______________________________

Brother: ______________________________

Sister: ______________________________

Other: ______________________________

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that I am responsible for my bill and that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: ______________________________ Date: __________

Thank you for taking the time to fill out this form in its entirety and for choosing

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