LABONTE DISC INSTITUTE Bill Labonte, D.C.

Confidential Health Profile

Date _____ **Name**_____ **Birth Date** _____ **Age** _____

Address _____ **City** _____ **State** _____ **Zip** _____ **SS#** _____

Home Phone # _____ **Work#** _____ **Cell#** _____ **Email** _____

Spouse or Parent's Name _____**Gender:** □ **Male** □ **Female** **Are you:** □ **Single** □ **Married** □ **Divorced** □ **Widowed**

Emergency Contact Name/Number_____**# of Dependants/Names**_____

What name do you prefer to use _____**Employment Status:** □ **Employed** □ **Student** □ **Retired** □ **Self-Employed** □ **Other**

Occupation/ Trade _____ **Employer** _____

Whom may we thank for referring you to the office? _____ **Have you ever had Chiropractic Care before?** □ **Yes** □**No**

If so, when and for what _____

Reason for today's visit _____**When did you notice the symptoms?** _____

What caused your symptoms to start? _____

Please list your problem areas or main concerns in order of severity and duration and what type of care you have tried so far:

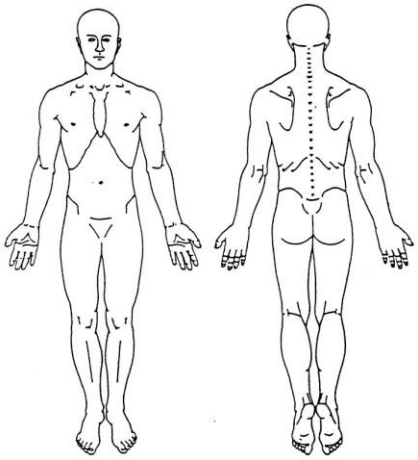
(1) _____ **For how long?** _____ **Type of care so far** _____

(2) _____ **For how long?** _____ **Type of care so far** _____

Body Diagram

Instructions: On the body diagram below, please indicate where your pain is located at the present time

Right Left Left Right



How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

How would you describe the type of pain?

□ Sharp	□ Numb
□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion
□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion
□ Shooting	□ Electric like with motion
□ Stiff	□ Other: _____

How are your symptoms changing with time?

□ Getting Worse
□ Staying the Same
□ Getting Better

Using a scale from 0-10 (10 being the most), rate your symptoms?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

Is your current condition interfering with your:

□ **Work/School** □ **Sleep** □ **Daily routine** □ **Sports/Exercise** □ **Social activities** □ **Other:** _____

What makes your problem worse? _____

What makes your problem better? _____

What is your current: **Height**_____ feet _____ inches **Weight** _____ lbs

How would you rate your overall Health? □ **Excellent** □ **Very Good** □ **Good** □ **Fair** □ **Poor**

(Please turn over to complete the back)

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss	□	□	Bone Loss/Osteopenia
□	□	Ankle/Foot Pain	□	□	Loss of Appetite			
□	□	Jaw Pain	□	□	Abdominal Pain	**For Females Only**		
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Birth Control Pills
□	□	Arthritis	□	□	Hepatitis	□	□	Hormonal Replacement
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder	□	□	Pregnancy
□	□	Cancer	□	□	General Fatigue	□	□	Menopause
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances	**Other**:		
□	□	Chronic Sinusitis	□	□	Dizziness	□	□	_____

List all medications/vitamins/herbal remedies/supplements you are currently taking:_____

_____

List all surgical procedures you have had: _____

_____

What activities do you do outside of work?_____

Have you ever been hospitalized? □ No □ Yes **~ If yes, why** _____

Have you had significant past trauma? □ No □ Yes ~ **Please explain**_____

Is there anything else pertinent to your visit today? _____

Acknowledgements:

□ ***Chiropractic Care:*** **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

□ ***Privacy Verification:*** **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved parties. I grant permission to be called to confirm or reschedule and appointment and to be sent occasional cards, letters, emails or health information to me as an extension of care in this office.**

□ ***Payment Verification:*** **I acknowledge that any insurance I may have is an agreement between the carrier and me, and that I am responsible for the payment of any covered or non-covered services I receive.**

□ ***X*-ray Verification:** **FEMALES ONLY – I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant or I understand the associated risks.**
Date of last menstrual period: _____

□ ***General Verification:*** **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern in any way.**

X_____ _____

Signature of Patient, Parent, Guardian or Personal Representation **Date**

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

Thank you for your trust and confidence.