LaValle Chiropractic and Family Wellness

Cover Sheet

1. Date entered in comp: ____________________ Account Number: __________________

Name: (L/F/M.I.):______________________________,___________________________,________

Address: ____

City: ____________________________________ State: ________________ Zip: ____________

Home Phone: _________________ Cell Phone: _________________ Work Phone: _____________

Birth Date: _____________ Gender: M F S.S.#: __________________

Date if Injury: ________________ Referred By: _____________________________

Date of 1st Visit: ______________ Employer: _______________ Occupation:___________

Who is Responsible for Bill: ☐SELF ☐SPOUSE ☐WORK COMP ☐MEDICARE

☐Auto INS. - ___Police report ___Auto Ins. all parties ___Attorney Info ___Attorney Lein or ___Doctors Lein ☐MAINE CARE (referral required) # of visits ______ Date Referral received: _____________

Referring Dr./Clinic:________________Phone #__________ Fax #:________ From: __/__/__ To: __/__/__

☐PERSONAL HEALTH INS. __________________________________ Referral Required: Y N

Date Referral Received: __________ Number of Visits Received: __________ Received From: ______________

ADDRESS OF INSURED IF DIFFERENT FROM CHILD: _________________________________

Contact in case of Emergency: ______________________________ Phone: ______________

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2. DIAGNOSIS:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

LEVELS:____

3. CHIROPRACTIC MANAGEMENT PLAN:

☐ Adjustment ☐Manual Traction

☐ Hot Compress ☐ NMT (Neuro Muscular Therapy)

☐ Cold Compress ☐ Orthotics

☐ EMG Scans/12 visits ☐ Other: ____________

LEVELS:____

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4. X-RAYS:

DATE: __________ COMMENTS: ______________________________

VIEW(S): __________ ______________________________

__________ ______________________________

__________ ______________________________

X-RAYS:

DATE: __________ COMMENTS: ______________________________

VIEW(S): __________ ______________________________

__________ ______________________________

__________ ______________________________

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5. SCANS DATE:_______________ DATE:_______________ DATE:_______________

COMMENTS:____

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6. VISITS _ **Welcome Letter** _ **Chiropractic First/Book** _ **Office Philosophy** _ **Financial Policies**

_ **Dr.s 1st phone call** _ **Health care class/Date Attended:**____________________

Confidential Patient Data

PATIENT INFORMATION Today's Date: __________

Name: ______________________________ Date of Birth: ______________
Address: ______________________________
City: ______________ State: ________ Zip: ________
Home Phone: ______________ Work Phone: ______________
Cell Phone: ______________ E-Mail: ______________
Social Security #: ______________ Age: ______ ☐ Male ☐ Female
Marital Status: ☐ Married ☐Single ☐Divorced ☐Separated ☐Other __________
Name of Spouse or Nearest Relative: ______________ Phone: ______________
Your Occupation ______________ Your Employer: ______________
Referred to this Office by: ☐Friend/Family Member - Name? ______________
☐Yellow Pages ☐ Mail ☐Clinic Location ☐Other __________

Are you covered by more than one insurance company? ☐Yes ☐No

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which PAST conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F	Condition	S	M	F	Condition	S	M	F	Condition
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	Stroke
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	tuberculosis
☐	☐	☐	venereal disease	☐ Other			__________	☐ Other			__________

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No

Describe Condition ______________________________ Date of Last Physical Exam __________

SURGICAL HISTORY:
1. ______________________________ Date: __________
2. ______________________________ Date: __________
3. ______________________________ Date: __________

Primary Care Physician: ______________ Tel #: ______________

ACCIDENT HISTORY:
☐Job ☐Auto ☐Other 1. ______________ Date: __________
☐Job ☐Auto ☐Other 2. ______________ Date: __________
☐Job ☐Auto ☐Other 3. ______________ Date: __________

Are both of your parents still alive? ☐Yes ☐No (please explain cause(s) death below) example (heart attack):

____

Your Kids ☐None ☐Boys; Ages __ __ __ __ __ ☐Girls; Ages __ __ __ __ __

Date of Injury/onset ______________

Please Describe Your Present Conditions:

Body Area ________________________________ *(example: low back, neck, headache)*
Please Circle Best Responses From Each Line Below

Pain Level: 1 2 3 4 5 6 7 8 9 10 (*1 is least, 10 is worst*)
Mild - Mild to Moderate – Moderate - Moderately Severe - Severe
Constant – Occasional – Intermittent - Frequent

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Please Check All Activities That Are Worsened By Your Present Condition

General

- ☐ Sitting
- ☐ Sleeping
- ☐ Sexual Intercourse
- ☐ Exercising
- ☐ Climbing Stairs
- ☐ Standing
- ☐ Running
- ☐ Sitting in Recliner
- ☐ Chewing
- ☐ Lifting Children
- ☐ Bending
- ☐ Getting In/Out of Vehicle
- ☐ Reading
- ☐ Lying in Bed
- ☐ Kneeling
- ☐ Swimming
- ☐ Using Computer

Housework

- ☐ Doing Laundry
- ☐ Carrying Groceries
- ☐ Making Beds
- ☐ Caring for Pets
- ☐ Vacuuming
- ☐ Cooking
- ☐ Washing Dishes
- ☐ Sweeping
- ☐ Ironing

Yard Work

- ☐ Mowing Lawn
- ☐ Raking Leaves
- ☐ Gardening

Personal Grooming

- ☐ Combing Hair
- ☐ Shaving
- ☐ In/Out of Bathtub

Travel

- ☐ Driving
- ☐ Riding as Passenger

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
☐COUGHING ☐SNEEZING ☐STRAINING AT STOOL ☐BENDING ☐CARRYING ☐CLIMBING A LADDER ☐CLIMBING STAIRS ☐DRIVING ☐EXERCISING ☐GETTING OUT OF BED ☐IN/OUT OF CAR ☐LIFTING ☐PULLING ☐PUSHING ☐REPETITIOUS MOVEMENTS ☐STANDING ☐STOOPING ☐WALKING UPHILL ☐WALKING ☐HEAT ☐COLD

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
☐CHIROPRACTIC CARE (ADJUSTMENTS) ☐TAKING ADVIL ☐TAKING ASPRIN ☐TAKING PAIN PILLS ☐TAKING TYLENOL ☐EXERCISING ☐RECLING ☐RESTING ☐SLEEPING ☐WALKING ☐COLD/ICEPACK ☐MASSAGING BY HAND ☐HEAT (HOT PACK) ☐RUBBING HEAT LINIMENT ☐HOT SHOWERS ☐RUBBING MINERIAL ICE ☐TUB SOAKING ☐MESSAGING (VIBRATOR)

Patient's Signature:______________________________ Date:____________________