ABC REHAB AND CHIROPRACTIC
1304 BERTRAND DR., SUITE E-3 LAFAYETTE LA 70506
PH: 337-706-7878

Patient Information:

Date: _____ SSN: _____ Birthday: _____
First Name: _____ Middle Name: _____ Last Name: _____
Sex o Male o Female Height: _____ Weight: _____
Married/Civil Union: _____ Spouse Name: _____ # of children: _____
Home #: _____ Cell #: _____ Work #: _____
Address: _____
City: _____ State: _____ Zip: _____
Emergency Contact: _____ Relation: _____ Phone #: _____
Email: _____

Chiropractic Experience:

Who referred you to our office: _____
Where did you hear about us? o Newspaper o Sign o Yellow Pages o Mailing o Community Event o Other
Have you been adjusted by a chiropractor before? oYes o No If yes, Why? _____
Doctor's Name: _____ Approximate date of your visit: _____

Employer Information:

Employed: _____ Employer Name: _____
Employer Address: _____
Employer City: _____ Employer State: _____ Employer Zip: _____
Occupation: _____ Work Supervisor: _____ Supervisor #:_____
Work Duties: _____

Personal Incident History:

Broken Bones: o Yes o No Treatment: o Yes o No Explian: _____
Sprain/Strains: o Yes o No Treatment: o Yes o No Explain: _____
Hospitalized: o Yes o No Explain: _____
Surgery: o Yes o No Explain: _____
Auto Accident: oYes o No Treatment: o Yes o No Explain: _____
Struck Unconscious: o Yes oNo Treatment: o Yes o No Explain: _____
Eating Disorder: o Yes o No Treatment: o Yes o No Explain: _____
Stroke: o Yes o No Treatment: o Yes o No Explain: _____

Please complete if you are Group Health, Medicare

Primary Insurance Carrier: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax #: _____
Name of Policy Holder: _____
SS# for Policy Holder: _____ DOB for Policy Holder: _____
Policy Number: _____ Group Number: _____
Employer (if group Policy) _____
[ ] I would like a copy of my clinic note sent to this insurance carrier.

Secondary Insurance Carrier: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax #: _____
Name of Policy Holder: _____
SS# for Policy Holder: _____ DOB for Policy Holder: _____
Policy Number: _____ Group Number: _____
Employer (if group Policy) _____
[ ] I would like a copy of my clinic note sent to insurance carrier.

Referring Physician: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

Attorney: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like my attorney to receive a copy of my clinic note.

Please list any other physician's that your have seen in the past for this problem or similar problem:

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

Physician Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax Number: _____
[ ] I would like a copy of my clinic note sent to this doctor.

All the above information is true and correct to the best of my knowledge.

_____ _____
Signature: Date:

Chief Complaint:

Please describe your chief complaint in detail and include the duration of the symptoms (onset of problem, location of pain numbness, tingling, rate your pain level, etc...)

_____

_____

_____

_____

_____

If this is the result of an accident please give date of accident: (month date year) _____

☐ Motor Vehicle Accident ☐ Work Related Injury ☐ Slip & Fall ☐ No apparent cause

☐ Altercation ☐ Assault ☐ other: _____

Please give date (month/day/year): _____

The onset of your symptoms has been:

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Fall ☐ Bending ☐ Pulling ☐ Insidious

☐ Twisting (☐ right ☐ left) ☐ Other: _____

What makes the pain worse?

☐ Nothing ☐ During exercise ☐ After exercise ☐ Prolonged sitting –length _____

☐ Prolong standing - length _____ ☐ Walking length _____ ☐ Bending forward

☐ Bending backward ☐ Pushing ☐ Pulling ☐ Squatting ☐ Night pain

☐ Changing Position ☐ Laying down ☐ Other: _____

What makes the pain better?

☐ Nothing ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking ☐ Medication

☐ Shifting/changing position ☐ Exercising ☐ Other: _____

Please check off which of the following you have had done:

☐ X-ray Where _____ ☐ MRI Where _____ ☐ Discography Where _____ ☐ CT Scan Where _____ ☐ EMG/NCS (electrical studies) Where _____

☐ Myelogram/CT Where_____ ☐ Bone Scan Where_____ ☐ Other (Please Specify):_____

What treatments have you had for this problem? (Check all that apply)

☐ Nothing ☐ Chiropractic Care ☐ Injections

☐ Physical Therapy

☐ Stretching ☐ Strengthening ☐ Traction ☐ Tens ☐ Pool Therapy

☐ Massage ☐ Ultrasound ☐ Heat/Ice

☐ Medications

☐ Muscle Relaxants ☐ Pain Medications ☐ Anti-Inflammatory (Prescription)

☐ Anti-Inflammatory – Over the Counter (Aspirin, Tylenol, Advil, etc)

☐ Other: (please specify): _____

If so, did you get relief? ☐ No ☐ Slight ☐ Marked ☐ Moderate

Course or Progression of Symptoms?

☐ Improving ☐ Unchanged ☐ Worsening

Patient Name:

Do you have any mobility needs?
☐ Cane ☐ Wheelchair ☐ Crutches ☐ Walker

Have you had other episodes of pain or injuries to your neck or back?

- ☐ No, never
- ☐ Yes, Once When? _____ (year)
- ☐ Yes, more than once
  - The first episode or injury was in _____(year)
  - The last episode or injury was in _____ (year)
  - Total number of episodes or injuries: _____ (year)
  - Frequency of these episodes or injuries: _____(year)

Patient is _____ right handed _____ left handed

Occupation _____
Current work status?

- ☐ Regular Employment – No Restriction
- ☐ Full – Time with Restrictions
- ☐ Part – Time by choice
- ☐ Part – Time for Medical Reasons
- ☐ Retired by Choice
- ☐ Retired by Medical Reasons
- ☐ Unemployed
- ☐ Currently not working for medical reasons
- ☐ Student
- ☐ Other –Specify _____

If no date last worked _____

_____

Have you ever seen a Cardiologist? [ ] Yes [ ] No If yes, who was the cardiologist that you saw?

_____

Allergies

Name of Allergies	Type of Reaction

Please use a separate sheet of paper to write any additional allergies

Do you have any allergies to iodine? [ ] No [ ] Yes
If yes, describe the nature of the reaction: _____