REBECCA LE, D.C.
TRUC LE, D.C.
5407 BASSWOOD BLVD. SUITE 101
FORT WORTH, TX 76137
PHONE: (817) 576-4111 FAX: (855) 315-6919
www.le-chiropractic.com

LE CHIROPRACTIC

PATIENT OR LEGAL GUARDIAN INITIALS: _____

PATIENT INFORMATION

THANK YOU for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to ask for assistance We will be happy to help! (PLEASE PRINT)

DATE: _____

PATIENT NAME: _____ *Prefer To Be Called*: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____ Email Address: _____

Marital Status: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ PARTNERED

Sex: ☐ M ☐ F Age: _____ Date of Birth: _____ # of Children: _____ SSN #: _____

Emergency Contact/Phone #: _____ Driver's License #/State: _____

Occupation: _____ Employer: _____ Phone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

PERSONAL INJURY INFORMATION: (*If applicable*)
Law Firm: _____ Attorney Name: _____ Date of Accident: _____
Attorney Address: _____ City: _____ State: _____ Zip: _____
Attorney #: _____ Attorney Fax: _____ Attorney Email Address: _____

Your Insurance Co.: _____ Adjustor Name: _____ Claim #: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Insurance #: _____ Insurance Fax: _____ Insurance Email Address: _____

3rd Party Insurance Co.: _____ Adjustor Name: _____ Claim #: _____
3rd Party Address: _____ City: _____ State: _____ Zip: _____
3rd Party #: _____ 3rd Party Fax: _____ 3rd Party Email Address: _____

How did you hear about us? _____
Referred by Someone, IF SO, WHO CAN WE THANK: _____

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PATIENT HISTORY

PATIENT NAME: _____ HEIGHT: _____ WEIGHT: _____

- Have you had Chiropractic Care before? ☐ Y ☐ N If YES, How recently? _____

REASON FOR VISIT: _____

_____

How/When did it start: _____

_____

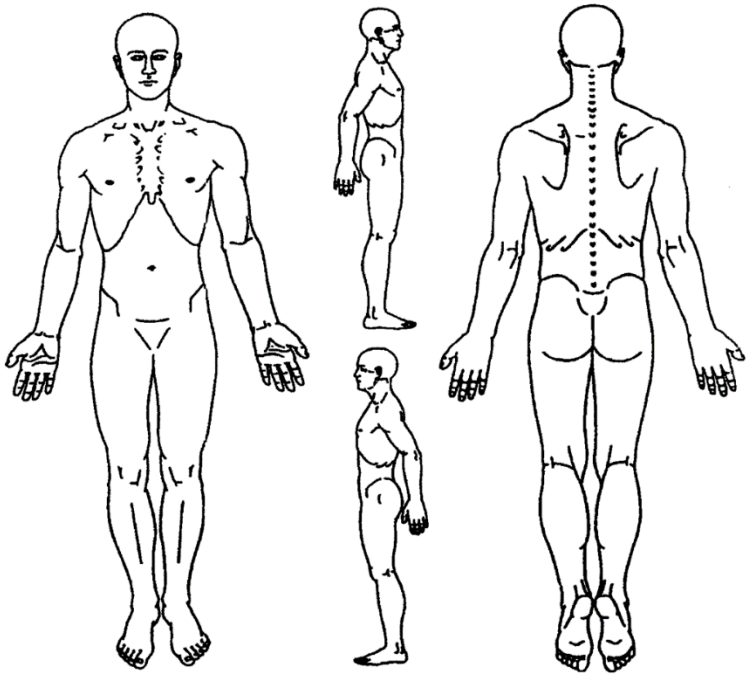
Is the condition getting progressively worse? _____

What is the frequency of your complaint(s): ☐ Constant Area: _____ ☐ Intermittent Area: _____

Where specifically is the problem(s) located: _____

- Mark the area(s) on the body below where you feel pain. Please include all affected areas.
- Mark area(s) of radiating pain.
  - If your pain radiates, draw an arrow from where it starts to where it stops.
- Use the appropriate symbol(s) listed below to describe your pain.
- Rate the SEVERITY of your Pain on the affected area(s): **0-10** (1 = Mild to 10 = Severe/Emergency)

Ache	>>>>>>	Numbness	======	Pins and Needles	↓↓↓↓↓↓	Burning	××××××
Stabbing	∇∇∇∇∇	Throbbing	~~~~~~	Tingling	+++++	Sharp	↔↔↔↔
Dull	0 0 0 0 0	Soreness	∩∩∩∩∩	Shooting	⊕ ⊕⊕ ⊕	Other	



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Have you experience the complaint(s) before? ☐ Y ☐ N If YES, when: _____

Are you currently experiencing any of the following?

☐ Nausea or Vomiting ☐ Difficulty Walking ☐ Fainting or lightheadedness ☐ Rapid Eye Movement
☐ Headache or neck pain ☐ Dizziness ☐ Difficulty Speaking ☐ Difficulty Swallowing
☐ Double Vision ☐ Numbness on one side of face/body

What activities make the complaint worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying Down ☐ Other: _____

Have you experienced any restrictions or difficulties in any Activities of Daily Living, Social and Recreational Activities because of your current condition? (Please describe in detail: such as; bathing, grooming, dressing, eating, driving, etc…)

☐ Y ☐ N If YES, Is the effect: ☐ Mild ☐ Moderate ☐ Severe

_____

_____

Have you experienced any restrictions or difficulties in performance of your job duties at work because of your current condition? (Please describe in detail)

☐ Y ☐ N If YES, Is the effect: ☐ Mild ☐ Moderate ☐ Severe

_____

_____

Have you missed any work as a result of the complaint? ☐ Y ☐ N If YES, how many days/weeks? _____

PAST MEDICAL HISTORY

MUSCULOSKELETAL COMPLAINTS/CONDITIONS (Please mark all that apply)

☐ Headaches/Migraines ☐ Shoulder Pain/Injury ☐ Ankle Pain/Injury ☐ Osteoporosis
☐ Neck Pain/Injury ☐ Elbow Pain/Injury ☐ Foot Pain/Injury ☐ Osteopenia
☐ Upper Back Pain/Injury ☐ Wrist Pain/Injury ☐ Arthritis ☐ Inflammation
☐ Low Back Pain/Injury ☐ Hand Pain/Injury ☐ Fused/Fixated Joints ☐ Swelling
☐ Pelvic Pain/Injury ☐ Hip Pain/Injury ☐ Herniated/Bugling Disc(s) ☐ Other: _____
☐ Sciatica ☐ Knee Pain/Injury ☐ Joint Replacement

OTHER HEALTH CONDITIONS: (Please mark all that apply)

☐ Cancer ☐ Depression ☐ Stroke ☐ Seizure Disorders ☐ Allergies
☐ Pacemaker ☐ Hernia ☐ Heart Disease ☐ AIDS/HIV ☐ Diabetes
☐ High Blood Pressure ☐ Hepatitis ☐ Tuberculosis ☐ Other: _____

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HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:

Surgeries:	☐ Y ☐ N	☐ Less than 1 month	☐ Within this last year	☐ _____ years
Accidents/Broken Bones:	☐ Y ☐ N	☐ Less than 1 month	☐ Within this last year	☐ _____ years
Hospitalizations:	☐ Y ☐ N	☐ Less than 1 month	☐ Within this last year	☐ _____ years

Reason for hospitalization: _____

Any Family History of diseases or death of parents, siblings, and/or children (i.e. heart problems, diabetes, asthma, hereditary disease(s), etc…) ☐ Y ☐ N ☐ If Yes, Describe: _____

_____

List ALL Medications/Vitamins: _____

List ALL Allergies: _____

Are you pregnant? ☐ Y ☐ N ☐ If Yes, how far along? _____
Nursing? ☐ Y ☐ N

Do you smoke or use any Tobacco Products? ☐ Y ☐ N ☐ If Yes, how much & often? _____
Do you drink Alcoholic Beverages? ☐ Y ☐ N ☐ If Yes, how much & often? _____
Do you drink Caffeinated Beverages? ☐ Y ☐ N ☐ If Yes, how much & often? _____

What treatments have you already received for your condition?
☐ Chiropractic ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other: _____
If Yes, Please list each doctor individually:

- DR. NAME: _____ SPECIALTY: _____ Date(s)Seen: _____
  Address: _____ City: _____ State: _____ Zip: _____
  Phone: _____ Fax: _____ Are you still treating? ☐ Y ☐ N
  Diagnostics Completed: ☐ XRAY ☐ MRI ☐ CT SCAN ☐ EMG/NCV ☐ BONE SCAN ☐ MYELO ☐ OTHER
  Diagnosis: _____ Procedures Completed: _____

- DR. NAME: _____ SPECIALTY: _____ Date(s) Seen: _____
  Address: _____ City: _____ State: _____ Zip: _____
  Phone: _____ Fax: _____ Are you still treating? ☐ Y ☐ N
  Diagnostics Completed: ☐ XRAY ☐ MRI ☐ CT SCAN ☐ EMG/NCV ☐ BONE SCAN ☐ MYELO ☐ OTHER
  Diagnosis: _____ Procedures Completed: _____

- DR. NAME: _____ SPECIALTY: _____ Date(s) Seen: _____
  Address: _____ City: _____ State: _____ Zip: _____
  Phone: _____ Fax: _____ Are you still treating? ☐ Y ☐ N
  Diagnostics Completed: ☐ XRAY ☐ MRI ☐ CT SCAN ☐ EMG/NCV ☐ BONE SCAN ☐ MYELO ☐ OTHER
  Diagnosis: _____ Procedures Completed: _____

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Who is filling out this questionnaire? ☐ Self ☐ Spouse ☐ Other: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered to the best of my knowledge. By providing my contact information, I am authorizing Le Chiropractic, LLC to send directly to me my personal financial and medical records by way of electronic and verbal communications, including but not limited to appointment reminders and messages. Message and data rates apply.

_____ _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

_____
PRINT PATIENT NAME/GUARDIAN

_____ _____
SIGNATURE OF DOCTOR *(once reviewed)* DATE