Libs Chiropractic Center, Inc.

Dr. David Libs & Dr. Lori Libs

PERSONAL HISTORY

Date: ______________________ Social Security No.: ______________________

Name: ______________________ Address: ______________________

City: ______________________ State: ______________ Zip: ________

Home Phone: ______________________ Business Phone: ______________________

Birthdate: ______________________ Age: _____ Sex: M F

Business/Employer: ______________________ Type of Work: ______________________

Do you do repeated lifting, bending, etc? ________ Do you sit for prolonged periods? ________

Check One: ❒Married ❒Single ❒Widowed ❒Divorced ❒Separated No. of Children ___

Your cell phone no.: ______________________ Email address: ______________________

Emergency contact and phone ______________________ Referred to this office by: ____________

Who is responsible for your bill: ❒Self ❒Spouse ❒Worker's Comp. ❒Medicaid ❒Medicare ❒Auto Insurance ❒Personal Health Insurance ❒Other

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CURRENT HEALTH CONDITION

Purpose of this appointment: ____

____

Other doctors seen for this condition: ____

When did this condition begin: ____

Do you smoke? _____ Pks/cigarettes/day Do you drink alcohol? _____ Drinks/day

Do you drink coffee? _____ Cups/day

Drugs

❒Antidepressants ❒Birth Control Pills ❒Pain Killers/Muscle Relaxers ❒Blood Pressure Medicine ❒Insulin ❒Other:

PAST HEALTH HISTORY

Please check and date

Major surgery/operations: ❒Appendectomy ❒Tonsillectomy ❒Gall Bladder ❒Hernia ❒Hysterectomy

❒Broken bones: ______________________ ❒Other: ______________________

Major accidents or falls: ____

____

Hospitalization (other than above): ____

____

Have you had previous chiropractic care? ❒Yes ❒No

If yes, who? ______________________ Results? ____________ When? ____________

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

√ CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ❒ Scarlet Fever
- ❒ Diptheria
- ❒ Typhoid Fever
- ❒ Pneumonia
- ❒ Rheumatic Fever
- ❒ Polio
- ❒ Malaria
- ❒ Tuberculosis
- ❒ Whooping Cough
- ❒ Anemia
- ❒ Small Pox
- ❒ Diabetes
- ❒ Cancer
- ❒ Heart Disease
- ❒ Goiter
- ❒ Pleurisy
- ❒ Alcoholism
- ❒ Venereal Infection
- ❒ Arthritis
- ❒ Epilepsy
- ❒ Mental Disorder
- ❒ Eczema

√ CHECK ANY OF THE FOLLOWING THAT'S A PROBLEM:

MUSCULO-SKELETAL

- ❒ Low Back Pain ____________
- ❒ Pain Between Shoulders ______
- ❒ Neck Pain ____________
- ❒ Arm Pain ____________
- ❒ Joint Pain/Stiffness ____________
- ❒ Walking Problems ____________
- ❒ Difficult Chewing/Clicking Jaw ___
- ❒ Knee Pain ____________

NERVOUS SYSTEM

- ❒ Numbness ____________
- ❒ Paralysis ____________
- ❒ Dizziness ____________
- ❒ Forgetfulness ____________
- ❒ Confusion/Depression ________
- ❒ Fainting ____________
- ❒ Convulsions ____________
- ❒ Cold/Tingling Extremities ______

GASTRO-INTESTINAL

- ❒ Poor/Excessive Appetite ______
- ❒ Excessive Thirst ____________
- ❒ Frequent Nausea ____________
- ❒ Vomiting ____________
- ❒ Diarrhea ____________
- ❒ Constipation ____________
- ❒ Hemorrhoids ____________
- ❒ Liver Trouble ____________
- ❒ Gall Bladder Problems ________
- ❒ Weight Trouble ____________
- ❒ Abdominal Cramps ____________
- ❒ Gas/Bloating After Meals ______
- ❒ Heartburn ____________
- ❒ Black/Bloody Stool ____________
- ❒ Colitis ____________

GENERAL

- ❒ Allergies (Food/Pollen) ________
- ❒ Loss of Sleep ____________
- ❒ Fever ____________
- ❒ Headaches ____________
- ❒ Fatigue ____________

GENITO-URINARY

- ❒ Bladder Trouble ____________
- ❒ Painful/Excessive Urination ______
- ❒ Discolored Urine ____________

C-V-R CODE

- ❒ Chest Pain ____________
- ❒ Short Breath ____________
- ❒ Blood Pressure Problems ________
- ❒ Irregular Heartbeat ____________
- ❒ Heart Problems ____________
- ❒ Lung Problems/Congestion ______
- ❒ Varicose Veins ____________
- ❒ Ankle Swelling ____________

EENT

- ❒ Vision Problems ____________
- ❒ Dental Problems ____________
- ❒ Sore Throat ____________
- ❒ Ear Aches ____________
- ❒ Hearing Difficulty ____________
- ❒ Stuffed Nose ____________
- ❒ Asthma/Hay Fever ____________

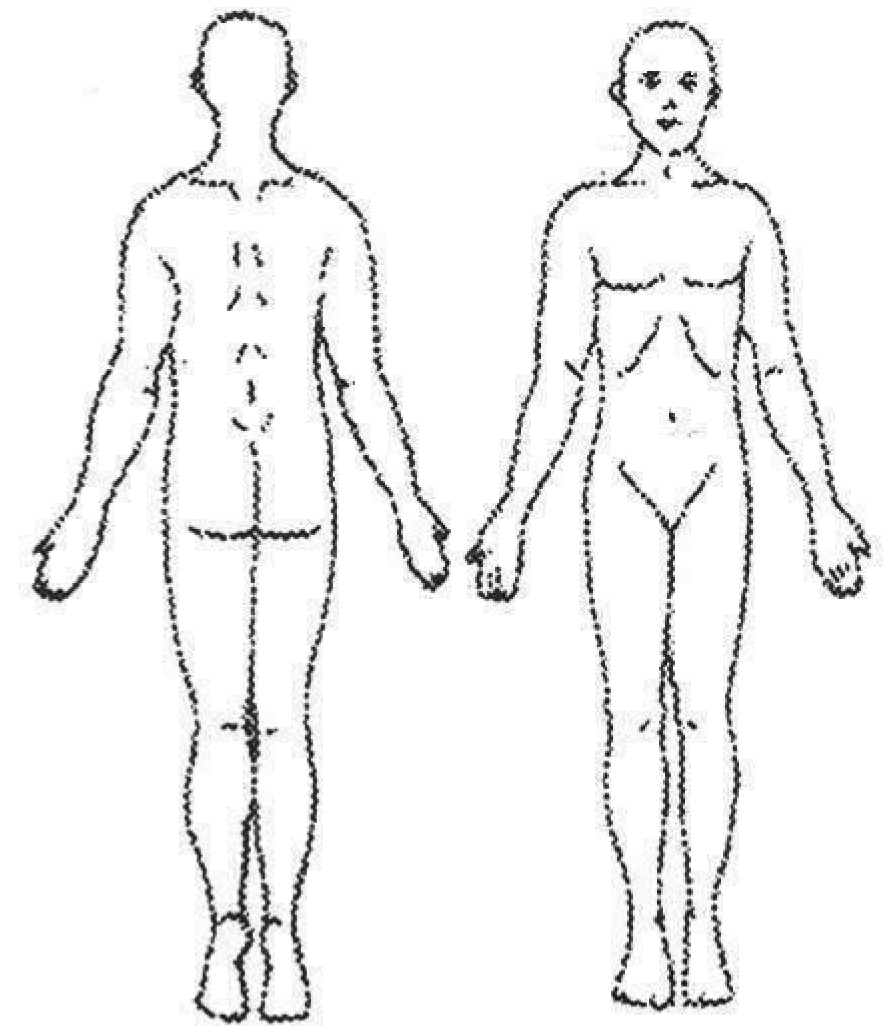
MALE/FEMALE CODE

- ❒ Menstrual Irregularity ________
- ❒ Menstrual Cramping ________
- ❒ Vaginal Pain/Infections ________
- ❒ Breast Pain/Lumps ________
- ❒ Prostate/Sexual Dysfunction ______
- ❒ Genital Herpes ____________

FEMALES ONLY:

When was your last period? ____________

Are you pregnant? ❒Yes ❒No ❒Maybe



Please outline on the diagram the area of your discomfort.

Do you exercise regularly? Yes No (please circle)

Run	Stairmaster
Walk	Swim
Bike	Stretch
Weights	____________
____________	____________

What type of bed do you sleep on? ____________

How old is it? ____________

Signature ________________________________ Date ____________

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chriopractic care (Comprehensive Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

❒ Relief Care ❒ Corrective Care ❒ Comprehensive Care ❒ Check here if you want the Doctor to select the type of care appropriate for your condition.