CONFIDENTIAL HEALTH INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards.
Date_______________

Full Name____
Address___________________________________City____________________State____Zip___________
Home Phone__________________ Cell Phone ___________________E-mail______________________

Gender: □ Male □ Female Date of Birth_______________ Age________
Marital Status: □ Single □Married □Widowed □Divorced □ Civil Union □ Partnered
Number of Children________

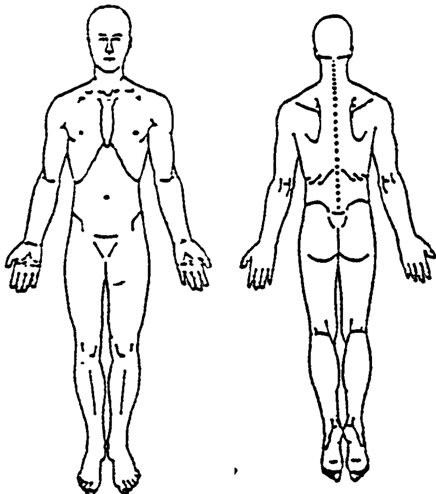
Employer________________________________Occupation_____________________________Phone_______________
Nature of Work ○Sitting ○Standing ○Light Labor ○Heavy Labor ○High Stress

Emergency Contact____________________________________ Phone___________________________

How did you hear about our office? ____

Presenting Illness

*1. The symptom(s) that have prompted me to seek care today include:*____
2. And are the result of (darken circle). ○ An accident or injury: ○ Work ○ Auto ○ Other______________________________
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other
3. *Onset* (When did you first notice your current symptoms?)____
4. *Intensity* (How extreme are your current symptoms?)) 0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ 10
Absent Uncomfortable Agonizing
5. *Duration and Timing* (When did it start and how often do you feel it?) ○ Constant ○ Come and goes. How often?_____
6. *Quality of symptoms* (What does it feel like?) Please circle all that apply.
Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting Throbbing Stabbing Other
7. *Location* (Where does it hurt?) Circle areas on the illustration. "0" for current condition; "X" for past conditions



Additional Doctor's Notes for Current Condition

Any loss of Bowel or Bladder function?
Any new medications or change in dose or brand with onset of symptoms?
Any dizziness, tunnel vision, other changes in vision, hearing, smell or taste?
Any chest pains or heart burn type symptoms especially upon exertion?

8. *Radiation* (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?
____

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9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem?____

What tends to lessen the problem?____

10. Prior interventions (What have you done to relieve the symptoms?) Circle all that apply.

Prescription medication   Over-the-counter drugs   Homeopathic remedies   Physical therapy   Surgery

Acupuncture   Chiropractic   Massage   Ice   Heat   Other____________________________

*11. What else should Dr. Heyn know about your current condition?*____________________

12. How does your current condition interfere with your:

Work or career:____

Recreational activities:____

Household responsibilities:_____________________________________

Personal relationships:____

13. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?) Please check one option for each activity.

Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect	Activity	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting					Grocery shopping				
Rising out of chair					Household chores				
Standing					Lifting objects				
Walking					Reaching overhead				
Lying down					Showering or bathing				
Bending over					Dressing myself				
Climbing stairs					Love life				
Using a computer					Getting to sleep				
Getting in/out of car					Staying asleep				
Driving a car					Concentrating				
Looking over shoulder					Exercising				
Caring for family					Yard work				

Review of Systems

Dr. Heyn needs to have a full understanding of your past health history in order to provide you with the highest quality of care today. In addition, Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've HAD or currently HAVE and initial beside NONE or at the bottom of each.

a. Musculoskeletal	Had	Have
NONE (Initials_____)		
Osteoporosis		
Knee Injuries		
Arthritis		
Foot/ankle pain		
Scoliosis		
Shoulder problems		
Neck pain		
Elbow/wrist pain		
Back problems		
TMJ issues		
Hip disorders		
Poor Posture		
Initials		

a. Neurological	Had	Have
NONE (Initials_____)		
Anxiety		
Depression		
Headache		
Dizziness		
Pins and needles		
Numbness		
Initials		

a. Cardiovascular	Had	Have
NONE (Initials_____)		
High Blood Pressure		
Low Blood Pressure		
Poor circulation		
Angina		
Excessive bruising		
Initials		

a. Respiratory	Had	Have
NONE (Initials_____)		
Asthma		
Apnea		
Emphysema		
Hay fever		
Shortness of breath		
Pneumonia		
Initials		

a. Digestive	Had	Have
NONE (Initials_____)		
Anorexia/bulimia		
Food sensitivities		
Heartburn		
Constipation		
Diarrhea		
Initials		

a. Sensory	Had	Have
NONE (Initials_____)		
Blurred vision		
Ringing in ears		
Hearing loss		
Chronic ear infection		
Loss of smell		
Loss of taste		
Initials		

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a. Integumentary	Had	Have
NONE (Initials_____)		
Skin cancer		
Psoriasis		
Eczema		
Acne		
Hair loss		
Rash		
Initials		

a. Endocrine	Had	Have
NONE (Initials_____)		
Thyroid issues		
Immune disorders		
Hypoglycemia		
Frequent infection		
Swollen glands		
Low energy		
Initials		

a. Genitourinary	Had	Have
NONE (Initials_____)		
Kidney stones		
Infertility		
Bedwetting		
Prostate issues		
Erectile dysfunction		
PMS symptoms		
Initials		

a. Constitutional	Had	Have
NONE (Initials_____)		
Fainting		
Low libido		
Poor appetite		
Fatigue		
Sudden weight gain/loss		
Weakness		
Initials		

Review of Systems Additional Doctor's Notes

Past Personal, Family, and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Personal

1. Illnesses Check the illnesses you have HAD in the past or HAVE now.

Had Have
____ ____ AIDS
____ ____ Alcoholism
____ ____ Allergies
____ ____ Arteriosclerosis
____ ____ Cancer
____ ____ Chicken pox
____ ____ Diabetes
____ ____ Epilepsy
____ ____ Glaucoma
____ ____ Goiter
____ ____ Gout
____ ____ Heart Disease
____ ____ Hepatitis
____ ____ HIV Positive
____ ____ Malaria
____ ____ Multiple Sclerosis
____ ____ Mumps
____ ____ Polio
____ ____ Rheumatic fever
____ ____ Scarlet fever
____ ____ Sexually Transmitted disease
____ ____ Stroke
____ ____ Tuberculosis
____ ____ Typhoid fever
____ ____ Ulcer
____ ____ Other________

2. Injuries
Have you ever…

____Had a fractured or broken bone
____Had a spine or nerve disorder
____Been knocked unconscious
____Been injured in an accident
____Used a crutch or other support
____Used neck or back bracing
____Received a tattoo
____Had a body piercing

3. Operations
Surgical interventions, which may or may not have included hospitalization.
____Appendix removal
____Bypass surgery
____Cancer
____Cosmetic surgery
____Elective surgery
____Eye surgery
____Hysterectomy
____Pacemaker
____Spine_______________
____Tonsillectomy
____Vasectomy
____Other

4. Treatments
Check the ones you've received in the PAST or are receiving CURRENTLY.
Past Currently
____ ____ Acupuncture
____ ____ Antibiotics
____ ____ Birth control pills
____ ____ Blood transfusions
____ ____ Chemotherapy
____ ____ Chiropractic care
____ ____ Dialysis
____ ____ Herbs
____ ____ Homeopathy
____ ____ Hormone replacement
____ ____ Inhaler
____ ____ Massage therapy
____ ____ Physical therapy
____ ____ Nutritional supplements

Doctor's Notes for past personal history:

Family History
Some health issues are hereditary. Tell Dr. Heyn about the health of your immediate family members.
Please indicate below if listed family members have/had a history of heart disease, diabetes, cancer, auto-immune disease or other major health issue.
Father ____
Mother____
Siblings____
____

Social
Tell Dr. Heyn about your health habits and stress levels.

Alcohol ____Daily ____Weekly How much?____________
Coffee ____Daily ____Weekly How much?____________
Tobacco ____Daily ____Weekly How much?____________
Exercising ___Daily ___Weekly How much?____________
___Walking ____Running ____Biking ____Weight lifting
___Other____
Pain relievers ____Daily ____Weekly How much?_______
Soft drinks ____Daily ____Weekly How much? ________
Water intake ____Daily ____Weekly How much?_______
Hobbies:____
____
Prayer or Meditation? ____Yes ____No
Job pressure/stress? ____Yes ____No
Financial peace? ____Yes ____No
Recreational drugs? ____Yes ____No
How many hours do you sleep a night?__________
Describe your typical eating habits:
____Skip breakfast; ____Two meals a day
____Three meals a day ____Snacking between meals
What would be the most significant thing that you could do to improve your health?_____________________________
In addition to the main reason for your visit today, what additional health goals do you have? ___________________
____

Additional Doctor's notes for Family and Social History:

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Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ By initialing here and signing below I indicate of have read the explanations below and have had my questions answered to my satisfaction. I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move you joints. That may cause and audible "pop", or "click," much as you have experienced when you "crack" you knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, basic neurological testing.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to car; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

____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 third parties.

____I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

____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.

____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.

If the patient is a minor child, print child's full name: ____

____ ____________________

Signature Date

____ ____________________

Doctor's signature that this document was reviewed in full Date

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