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_____

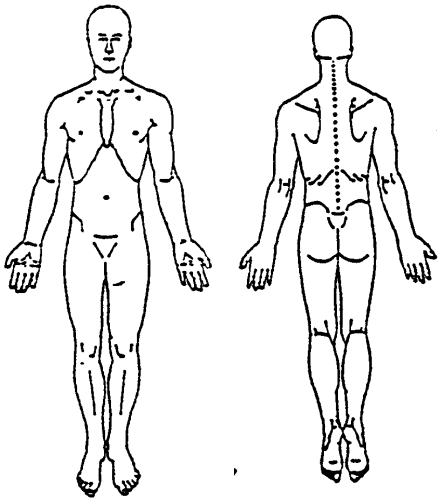
Employer_____Occupation_____Phone_____
Nature of Work ○Sitting ○Standing ○Light Labor ○Heavy Labor ○High Stress

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 check the appropriate box beside any condition that you've HAD, currently HAVE or have NEVER had.

Condition	Never	Had	Have	Condition	Never	Had	Have	Condition	Never	Had	Have
a. Musculoskeletal											
Osteoporosis				Scoliosis				Back problems			
Knee injuries				Shoulder problems				TMJ issues			
Arthritis				Neck pain				Hip disorders			
Foot/Ankle Pain				Elbow/wrist pain				Poor posture			
b. Neurological											
Anxiety				Headache				Pins and needles			
Depression				Dizziness				Numbness			
c. Cardiovascular											
High blood pressure				Poor circulation				Excessive bruising			
Low blood pressure				Angina							
d. Respiratory											
Asthma				Emphysema				Shortness of breath			
Apnea				Hay fever				Pneumonia			
e. Digestive											
Anorexia/bulimia				Heartburn				Diarrhea			
Food sensitivities				Constipation							
f. Sensory											
Blurred vision				Hearing loss				Loss of smell			
Ringing in ears				Chronic ear infections				Loss of task			
g. Integumentary											
Skin cancer				Eczema				Hair loss			
Psoriasis				Acne				Rash			
h. Endocrine											
Thyroid issues				Hypoglycemia				Swollen glands			
Immune disorders				Frequent infection				Low energy			

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Condition	Never	Had	Have	Condition	Never	Had	Have	Condition	Never	Had	Have
i. Genitourinary											
Kidney stones				Bedwetting				Erectile dysfunction			
Infertility				Prostate issues				PMS symptoms			
j. Constitutional											
Fainting				Poor appetite				Sudden weight gain/loss			
Low libido				Fatigue				Weakness			

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

5. Medications

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 pressure/stress? ____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 Personal, 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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