CONFIDENTIAL HEALTH INFORMATION UPDATE

The last time you were seen in our office was:_____
Date_____

Full Name_____
Address_____City_____State____Zip_____
Home Phone_____ Cell Phone _____E-mail_____

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

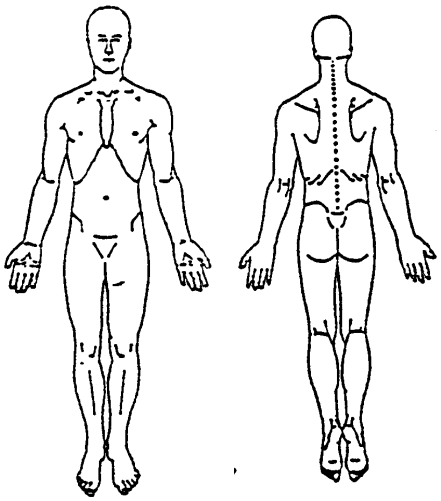
3. Onset (When did you first notice your current symptoms?)_____

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?
_____

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:_____

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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				

Changes to Health History

Please provide Dr. Heyn with any major illnesses, new diagnoses, hospitalizations, or surgeries since your last visit:

_____

_____

_____

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 signing below I indicate of have read the explanations provided upon request for informed consent 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.**

_____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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