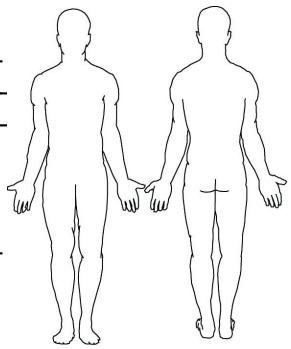
Lighthouse Chiropractic **Drs. Brent and Windy Heyn, D.C.** **Doctor's Initials_____**

Personal Information



First Name _____M.I._____Last Name_____
Address_____City_____State_____ Zip_____
Cell Phone _____ Other Phone _____
Date of Birth_____Gender: O Male O Female O Unspecified
Marital Status: O Single O Married O Widowed O Divorced O Civil Union O Partnered
Employer_____Occupation_____
Emergency Contact_____Phone_____
How did you hear about our office? O Patient O Physician O Other _____
Have you ever received Chiropractic Care? O Yes O No
Name of Primary Care Physician_____
May we contact/send progress notes to your Primary Care Physician? O Yes O No

What is the reason for your visit today? O Neck Pain O Mid-Back Pain O Low Back Pain
O Other_____

Fill out a section below for each area of complaint and mark them on the body diagram above.

Area:_____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Did the symptom begin suddenly or gradually? (circle one)

How did the symptom begin? O Accident O Injury O Unknown O Other_____

What makes the symptom better? (circle all that apply) Rest, ice, heat, stretching, massage, medication, nothing, Other (please describe):

_____

What makes the symptom worse? (circle all that apply) Bending, rotation, sitting, standing, getting up from sitting position, lifting, any movement, walking, running, nothing, other (please describe):

_____

Describe the quality of the symptom (circle all that apply) Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, Other (please describe):

_____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate?

_____

Is the symptom worse at certain times of the day or night? (circle) Morning Afternoon Evening During Night Unaffected by time of day

Area:_____

On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

What percentage of the time you are awake do you experience the above symptom at the above intensity:
5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

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_____

Does the symptom radiate to another part of your body (circle one): yes no

If yes, where does the symptom radiate?

_____

Is the symptom worse at certain times of the day or night? (circle) Morning Afternoon Evening During Night Unaffected by time of day

Patient Name _____DOB_____Date_____

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Review of Systems and Health History

Have you had or do you have any of the following:

Pulmonary (lung-related) *issues?*

□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ ***None of the above***

Cardiovascular (heart-related) issues or procedures?

□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs
□ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat
□ Other _____ □ ***None of the above***

N**eurological (nerve-related)** issues?

□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell
□ Strokes/TIAs □ Other _____ □ ***None of the above***

E**ndocrine (glandular/hormonal)** related issues or procedures?

□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes
□ Other _____ □ ***None of the above***

R**enal (kidney-related)** issues or procedures?

□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control)
□ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis
□ Other _____ □ ***None of the above***

G**astroenterological (stomach-related)** issues?

□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia
□ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease
□ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence
□ Gastroesophageal reflux/heartburn □ Other _____ □ ***None of the above***

Hematological (blood-related) issues?

□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive
□ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia
□ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy
□ Regular aspirin use □ Other _____ □ ***None of the above***

Dermatological (skin-related) issues?

□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders
□ Other _____ □ ***None of the above***

M**usculoskeletal (bone/muscle-related)** issues?

□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery
□ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants
□ Other _____ □ ***None of the above***

P**sychological** issues?

□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder
□ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations
□ Other _____ □ ***None of the above***

Do you have a history of any type of cancer? O Yes O No If so, specify below:

_____

Previous Injuries, Trauma or Broken Bones? O N/A

_____

Allergies? (Food, Drug, Environmental) **O N/A**

_____

Medications? (and reason for taking) **O N/A**

_____

_____

_____

Patient Name _____DOB_____Date_____

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Surgeries? Date Type of Surgery **O N/A**

_____

_____

_____

Females: Pregnancies and outcomes: Pregnancies/Date of Delivery/Outcome **O N/A**

_____

_____

_____

Family Health History

Do you have a family history of? (Please indicate all that apply)

□ Cancer □ Strokes/TIA's □ Hypertension □ Cardiac disease □ Neurological diseases □ Adopted/Unknown
□ Cardiac disease below age 40 □ Psychiatric diagnoses □ Diabetes □ Autoimmune Disorder □ Other _____
□ None of the above

Cause of parents or siblings death

Father _____ Age at Death_____ N/A
Mother _____ Age at Death_____ N/A
Sibling _____ Age at Death_____ N/A
Sibling _____ Age at Death_____ N/A

Social and Occupational History

Job Activities: O Sitting O Standing O Light Labor O Heavy Labor O Other _____
Work schedule: O Days O Nights O Swing O Other _____
Smoking Status: O Never O Former O Smoker _____ pack/day _____ years
Caffeine: O No O Yes How many per day? _____ Type(s) _____ (coffee, tea, energy drinks, soda,etc.)
Drug Use: O No O Yes Type(s) _____ Frequency: O Daily O Frequent O Occasional
Exercise: O No O Yes Times per week: _____ Intensity: O Light O Moderate O Intense
Recreational activities/Hobbies: _____

Doctor's Notes

Patient Name _____DOB_____Date_____

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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 sign below in agreement.

1. By 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 your joints. That may cause and audible "pop", or "click," much as you have experienced when you "crack" your 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 care; 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.

2. I may request a copy of the HIPPA 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.

3. 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. If you would like text reminders, please list your cell phone carrier: _____

4. 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.

5. 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: _____

_____ _____ _____
Print Signature Date

_____ _____ _____
Physician Print Name Physician's Signature that this document was reviewed in full Date

Patient Name _____DOB_____Date_____

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