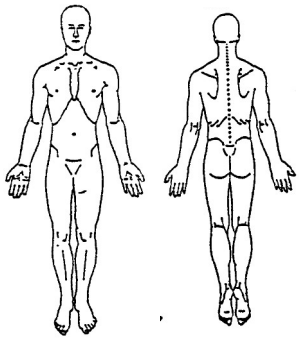
CONFIDENTIAL HEALTH INFORMATION UPDATE

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

Full Name_____
Address_____City_____State____Zip_____
Home Phone_____ Cell Phone _____Cell Phone Carrier_____
E-mail_____

Presenting Illness



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, taste, speech?
Any chest pains or heart burn type symptoms especially upon exertion?

Please mark area(s) of concern above.

1. **Reasons for seeking chiropractic care:**

Primary Area of Complaint:_____
Secondary Area of Complaint:_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____

3. **Details for Reasons for Care**

Primary Area of Complaint _____

- 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
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, 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, driving, 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 one)
  - Morning Afternoon Evening Night Unaffected by time of day

8 Ferry Road / South Hero, VT 05486 /802-372-5800
349 Route 7 South / Milton, VT 05468 / 802-893-0001
Fax: 802-372-5881 / www.lighthouse-chiro.com
drbrent@lighthouse-chiro.com / drwindy@lighthouse-chiro.com

Secondary Area of Complaint _____

- 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
- When did the symptom begin? _____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin? _____
- What makes the symptom better? (circle all that apply):
  - Rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, 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, driving, 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 one)
  - Morning Afternoon Evening Night Unaffected by time of day

(If you have more than two reasons for care, additional worksheets are available when you arrive at our office.)

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 sign at the bottom.

1. **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.**

2. 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.

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.

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	DOB	Date

8 Ferry Road / South Hero, VT 05486 /802-372-5800
349 Route 7 South / Milton, VT 05468 / 802-893-0001
Fax: 802-372-5881 / www.lighthouse-chiro.com
drbrent@lighthouse-chiro.com / drwindy@lighthouse-chiro.com

_____ _____

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

8 Ferry Road / South Hero, VT 05486 /802-372-5800
349 Route 7 South / Milton, VT 05468 / 802-893-0001
Fax: 802-372-5881 / www.lighthouse-chiro.com
drbrent@lighthouse-chiro.com / drwindy@lighthouse-chiro.com