



Heartland Chiropractic — and Wellness Center

Today's Date: ___/___/___ File: _____

Name: _____

Male Female SS#: _____

Date of Birth: ___/___/___ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Employer: _____

Occupation: _____

Phone: (H) _____ (Other) _____

In case of an emergency, contact: _____

Relationship: _____ Phone: _____

Marital Status: Single Married Divorced Separated
 Widowed Partnered Minor

Spouse's Name _____ Date of Birth: _____

Spouse's Employer/Occupation: _____

Have you seen a chiropractor before? Yes No

If yes, what for: _____

How did you hear about our clinic? _____

Patient Condition

Reason for Visit: _____

When did your symptoms begin? _____

Is the condition getting worse? Yes No

Is the pain: Constant Comes and goes

Type of pain: Sharp Dull Throbbing Ache
 Tingle Numbness Shooting Burning
 Stiffness Cramping Swelling other _____

Rate the severity of pain (0-no pain, 10-severe): _____

Does it affect: Work Sleep Daily Activity

Activities that are painful: Sitting Lying down
 Standing Walking Bending All activity

Insurance Information

Insured's Name: _____

Date of Birth: ___/___/___ SS#: _____

Relationship to patient: _____

Insured's Employer: _____

Insurance Company: BC/BS (PPO) Medicare Coventry
 United Health Care Other: _____

Insurance ID#: _____

Group #: _____ Plan/Program: _____

Assignment and Release: I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Valerie Skow/Lindsey Murray all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE PRINT
Name of Patient, Parent, Guardian or Personal Representative

Accident Information

Is condition due to an accident: Yes No

Type of accident: Auto Work Other _____

Date of accident: ___/___/___

Has the accident been reported: Yes No

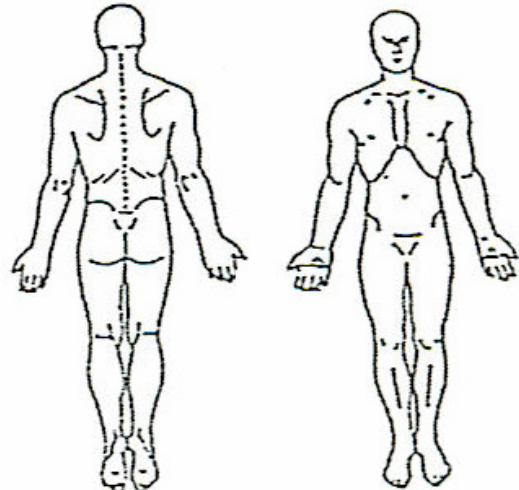
To whom: _____

Attorney's Name: _____ #: _____

Claim #: _____

Contact: _____ Company: _____

Please mark an X on the picture of the involved areas:



Have you received other treatments for your condition?

- Surgery Medications Physical Therapy Chiropractic
- Other: _____

Names of Doctors who have treated you for your condition:

- Other Symptoms:** Headache Pins/Needles in arm/legs
 Arm or leg pain Loss of smell or taste Numbness in fingers/toes Constipation/Diarrhea Cold hands/feet
 Shortness of breath Fatigue Upset stomach
 Depression Loss of balance Shoulder pain
 Ear ringing Loss of memory Chest pain Irritability
 Dizziness/fainting Nervousness Tension

Daily Habits

- Sleep position:** Stomach Side Back
Work Position: Sitting Standing Heavy labor Light labor
 Computer work Is your work station ergonomically correct? Yes No
Exercise: None Moderate Daily Heavy
Do you smoke? Yes No Packs/Day _____
Do you drink alcohol? Yes No Drinks/week _____
Do you drink caffeine? Yes No Cups/day _____
Do you have a high stress level? Yes No _____
What vitamins/supplements are you taking? _____

What medications are you taking? _____

Health History

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head injuries	_____	_____
Broken bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____
Auto Accidents	_____	_____
Other	_____	_____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes
Mother's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When you were a child did you have a difficult birth? Yes No
If yes, which of the following: C-section Breach Forceps

Are you pregnant? Yes No Due Date: _____

Please mark the box next to each item if you *have had* any of the following:

- AIDS/HIV
- Alcoholism
- Allergy Shots
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical dependency
- Chicken pox
- Diabetes
- Emphysema
- Epilepsy
- Fractures
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart disease
- Hepatitis
- Hernia
- Herniated disk
- Herpes
- High blood pressure
- High cholesterol
- Kidney Disease
- Liver Disease
- Measles
- Migraine headaches
- Miscarriage
- Mononucleosis
- Multiple sclerosis
- Mumps
- Osteoporosis
- Pacemaker
- Parkinson's disease
- Pinched nerve
- Pneumonia
- Polio
- Prostate problem
- Prosthesis
- Psychiatric care
- Rheumatoid arthritis
- Rheumatic fever
- Scarlet fever
- STD's
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Tumors, growths
- Typhoid fever
- Ulcers
- Vaginal infections
- Whooping cough
- Other _____

I certify that I have read and understand the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature: _____
 Date: ____/____/____