HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

5521 N.W. 86th Street · Johnston, IA · phone 515.252.8668
fax 515.270.2457 · www.HeartlandWellnessCenter.com

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

Name: _____

☐ Male ☐ Female SS#: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Phone: (C) _____ (H) _____

E-mail: _____ (*used for appt. reminder*)

Employer: _____

Occupation: _____

In case of an emergency, contact: _____

Relationship: _____ Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Minor
☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name:_____ Date of Birth _____

Spouse's Employer/Occupation: _____

May we leave voicemail messages and email regarding your health information/recommendations and appointments to you using the information listed above? ☐ Yes ☐ No

How did you hear about our clinic? _____

**** Ask about our referral program!***

Patient Condition

Reason for Visit: _____

Are you pregnant? ☐ Yes ☐ No Due Date:_____

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

Release of Information

Who do you authorize HCWC to provide your private healthcare information regarding your appointments, payments, etc.,

Parent_____ DOB _____
Spouse/Partner_____ DOB _____
Doctor _____ DOB _____
Other _____ DOB _____

*** If you would like to consider our Time of Service (Cash) Plan, please request information at the front desk.**

Insurance

Policy Holder's Name: _____

Date of Birth: _____ SS# _____

Relationship to Patient: _____

Policy Holder's Employer _____

Insurance Company: ☐ BC/BS (PPO) ☐ Medicare ☐ Coventry

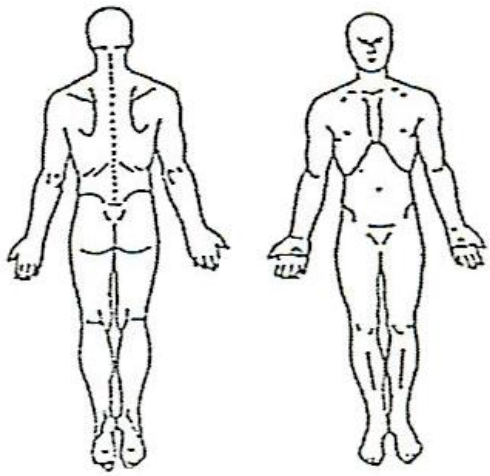
☐ United Health Care ☐ Other_____

Insurance ID# _____Group#_____

Assignment and Release: I certify that I, and/or my dependents(s), have insurance coverage with above insurance company and assign directly to Valerie Skow/Juliet O'Donnell/Naomi Behne 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**

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 ☐ Upset stomach

☐ Numbness in fingers/toes ☐ Constipation/Diarrhea

☐ Cold hands/feet ☐ Shortness of breath ☐ Fatigue

☐ Depression ☐ Loss of balance ☐ Shoulder pain ☐ Ear ringing

☐ Loss of memory ☐ Chest pain ☐ Irritability ☐ Tension

☐ Dizziness/fainting ☐ Nervousness

Daily Habits

Sleep Position: ☐ Stomach ☐ Side ☐ Back
Work Position: ☐ Sitting ☐ Standing ☐ Heavy labor ☐ Light labor
Computer Work: Is your workstation ergonomically correct?
☐ Yes ☐ No

Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Do you smoke? ☐ No ☐ Yes 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?

_____

Is there a family history of: *Heart Disease Arthritis Cancer Diabetes*

Mother's side	☐	☐	☐	☐
Father's side	☐	☐	☐	☐

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: _____

Authorization to Treat a Minor (*if under 18-years*)

I, _____ authorize treatment of my child, _____ without my presence to be treated by Dr. Valerie Skow and/or Juliet O'Donnell, and licensed massage therapists employed by Heartland Chiropractic and Wellness Center.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

Signature: _____

Date: _____

Health History

Injuries/Surgeries: Description Date

Falls _____
Head injuries _____
Broken bones _____
Dislocations _____
Surgeries _____
Auto Accidents _____
Other _____

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 Name (print): _____

Patient's Signature: _____

Date: _____/_____/_____