Heiland Chiropractic

General Information

Name_____ **Social Sec. #**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Home Phone_____ **Cell Phone** _____
Age_____ **Birth Date**_____ **How many Children?** _____
Email_____
Employer_____ **Occupation** _____
Business Address _____ **City**_____ **State**_____ **Zip**_____
Business Phone_____ **Business Email**_____
Emergency Contact _____**Phone #**_____
Marital Status □ Single □ Married □ Widowed □ Separated □ Divorced
Sex □ Male □ Female
Race □ American Indian □ Alaska Native □ Asian □ Black or African America
□ Native Hawaiian □ Other Pacific Islander □ White □ Declined to State
Ethnicity □ Declined to State □ Hispanic or Latino □ Not Hispanic or Latino

Language _____

Who may we thank for referring you? _____

Primary Insurance

Relation to Insured: □ Self □ Husband □ Wife □ Child □ Other
Name _____
Address_____ **City**_____ **State**_____ **Zip** _____
Birth Date _____ **Cell Phone** _____
Sex: □ Male □ Female
Employer _____ **Address**_____
Insurance Company_____
Phone Number_____
Insurance ID _____ **Group #**_____
Secondary Insurance □ Yes□ No

Reason for Visit

Your reason for ***this*** visit: _____
Please describe current pain and its location: _____
Are your current symptoms a result of an auto or other accident? _____
When did symptoms begin (date)? _____ Have you had a similar condition in the past? □ Yes □ No
Is the pain getting: □ Worse □ Better □ Same □ Comes and goes
How often do you have this pain? _____
Have you been treated by a medical physician for this condition? _____
If so, when and where? _____
Activities that are difficult to perform: □ Sitting □ Walking □ Bending □ Lying down □ Lifting
Type of Pain: □ Sharp □ Dull □ Throbbing □ Aching □ Burning □ Tingling □ Numbness
□ Cramping □ Stiffness □ Swelling □ Other _____
Is the pain interfering with: □ Work □ Sleep □ Daily Routine □ Recreation
Have you ever seen a Chiropractor? □ Yes □ No If yes, When and where? _____

Health History

Please list any medications (including over the counter) you are taking: _____

_____

Do you have any allergies to medication? □ Yes □ No

If yes, please list allergies: _____

Please list any serious injuries, broken bones or surgeries you have had in the last 10 years:

Description	Date
_____	_____
_____	_____

Women: Are you pregnant? □ Yes □ No Due Date? _____ Nursing? □ Yes □ No

Family History	Cancer	Diabetes	Back Pain	Other
Mother	□	□	□	□_____
Father	□	□	□	□_____
Sibling	□	□	□	□_____

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

□ Heart Attack/Stroke
□ Congenital Heart Defect
□ Fainting/Seizure/Epilepsy
□ Shingles
□ Psychiatric Problems
□ Hepatitis
□ Anemia
□ Artificial Bones/Joints
□ Digestive Issues
□ Arthritis
□ Neck Pain
□ Jaw Pain
□ Dizziness
□ Emphysema
□ Glaucoma
□ Earaches
□ Cancer
□ Ringing in Ears
□ Headaches
□ Diabetes
□ Wrist/Shoulder/Arm Pain
□ Leg Pain
□ Lower Back Problems
□ Kidney Problems
□ HIV Positive/AIDS
□ Ulcer/Colitis
□ Gout
□ Numbness, Where? _____
□ Tingling, Where? _____
□ Muscle Spasms, Where? _____

Personal Habits

Alcohol □ Yes □ No How much? _____

Sleep □ Normal □ Interrupted Comments_____

Exercise □ No □ Yes □ How Often _____

Tobacco □ Never □ Former □ Current, How Much? _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Steven K. Heiland, D.C., P.C. to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform Steven K Heiland, D.C., P.C. I authorize my insurance company to pay Steven K. Heiland D.C., P.C. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the Steven K. Heiland, D.C., P.C. to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. It is understood that any and all X-Rays taken will remain a permanent record of Steven K. Heiland, D.C., P.C.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.