Steven K. Heiland D.C., P.C.

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

Primary 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? □ Yes □ No
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 any health care professional for this condition? □ Yes □No
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
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 When is your due date _____ Nursing? □ Yes □ No
If X-rays are recommended, your signature is required (below) to indicate that you are not pregnant

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? _____
Exercise □ Yes □ No How often?_____
Sleep □ Normal □ Interrupted Please explain _____
Smoking Status □ Current □ Former □ Vape □ Never Smoked

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 health status, I will inform Steven K. Heiland, D.C. P.C. To the extent I fully assign my rights and benefits under my health plan to Steven K. Heiland, D.C. P.C. including but not limited to the right to receive payment directly, to participate in any and all coverage determination process with my plan, appeal denials or reductions in benefits or payment for such benefits up to and including pursuing litigation to enforce those rights and benefits on my behalf. I authorize the use of this signature on all insurance claims for reimbursement. To pay Steven K. Heiland, D.C., P.C. 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.