Dr. Kami Hansen
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Confidential Patient Information

Name_____ Age_____ Date of Birth___/___/___ Sex: M F
Address_____ City_____ State_____Zip_____
Home Phone (_____)_____Cell Phone (_____)_____Work Phone (_____)_____
Primary Contact Number: Home Cell Work Cell phone carrier:_____
E-mail_____ Would you like to receive office communications via email? Y N
Marital Status: S M D W # Children____ Spouse's Name_____ **SSN**_____
Occupation_____ Employer_____
Race_____Ethnicity_____Hispanic/Non-Hispanic
Emergency contact/phone number_____
Your health insurance company: _____ **Please bring copy to appointment.**
Insured's Name_____Insured's Date of Birth_____/_____/_____
Family Physician_____Facility_____

Whom may we thank for referring you to us/how did you hear about our clinic? _____

Are you currently enrolled in college? ☐Yes ☐No ☐Part time ☐Full time

Do you have a current military ID? ☐ Yes ☐ No

Main Complaint? _____

How do you want us to handle your problem? ☐Temporary relief (Help the symptom)

☐ Maximum correction (Correct the cause for maximum stability in the future)

Are your present problems due to an injury? ☐ Yes ☐ No ☐ On the Job ☐Auto Accident ☐Other_____

If this is due to an accident, has the accident been reported? ☐ Yes ☐ No ☐ Employer ☐ Auto Insurance Carrier ☐ Other_____

If yes, please also fill out Workers Comp or Personal Injury Form

Is this injury case still open? ☐Yes ☐No ☐Unsure Have you retained an attorney? ☐Yes ☐ No

Women Only:

To the best of my knowledge: ☐I am pregnant ☐ I am NOT pregnant and

☐ give my permission ☐ do NOT give my permission to x-ray me for diagnostic interpretation

MEDICATIONS

List all Drugs you are taking (include prescription and over the counter medications). Use back of sheet if necessary.

Type	Purpose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name:_____

PAST HISTORY

List all Surgeries, Falls, Auto Accidents, and Injuries (even those you thought were no big deal) and year if known:

_____

_____

_____

_____

Past Chiropractic Care: ☐Yes ☐No Who? _____ Last adjustment?_____Good Results? ☐Y ☐N

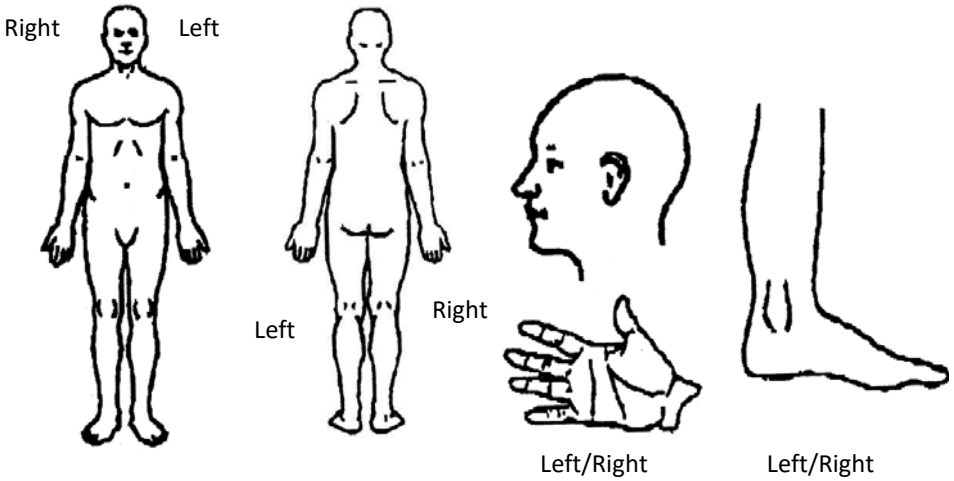
Past Physical Therapy: ☐Yes ☐No For? _____When? _____Good Results? ☐Y ☐N

ACTIVITIES OF DAILY LIVING (ADL's)

1. Type of mattress (describe)_____How old?_____
2. Sleeping position? ☐Side ☐Stomach ☐Back ☐ Combination
3. Type of pillow? ☐Foam ☐Feather ☐Other _____ How many? _____ How old? _____
4. Do you sit on your wallet? ☐ Yes ☐ No
5. Define your stress level (use 1-10 scale, 10 being the most stressful). _____ work _____ home
6. Do you have current pain with any of the following (mark all that apply):

☐ Dressing	☐ Stairs	☐ Lifting	☐ Doing Dishes	☐ Standing	☐ Getting Out Of Bed
☐ Walking	☐ Riding	☐ Working	☐ Bending	☐ Reaching	☐ Energy Increases
☐ Sit to Stand	☐ Sleeping	☐ Driving	☐ Exercising	☐ Sitting	☐ Getting On/Off Toilet
☐ Housework_____				☐ Yard work _____	

Please circle area and type of pain on the drawings below using the codes listed below



N- Numbness	TH-Throbbing
P – Pain	SW-Swelling
SB-Stabbing	D – Dull
SH – Sharp	SO-Shooting
T – Tingling	B-Burning
A – Ache	C-Cramps
ST – Stiffness	S – Soreness
MS-Muscle Spasm	O-Other

Name:_____

PERSONAL HISTORY

Mark "C" for current and "P" for past. Please mark "C" or "P" on all categories below that apply.

GENERAL SYSTEMS
__Cancer
__Diabetes
__Dizziness
__Epilepsy
__Fatigue(General/Muscular)
__Headache
__Hernia
__Loss of Sleep
__Migraines

GASTRO-INTESTINAL
__ Belching or Gas
__Constipation
__Diarrhea
__Excessive Hunger/Thirst
__Heartburn/Acid Reflux
__Ulcers

SKIN
__Bruise Easily
__Eczema/Psoriasis
__Hives

SPINE/BACK
__Ankle/Foot R / L
__Broken Bones
__Difficulty while **(please circle)** standing walking sitting bending lifting twisting
__Elbow R / L
__Herniated Discs
__Hip R / L
__Jaw Pain (TMJ) R / L
__Knee R / L
__Lower Back Pain R / L
__Mid Back Pain R / L
__Numbness, Tingling or Pain in Buttocks, Legs, Thighs, Feet, Toes R / L
__Numbness, Tingling or Pain in Arms, Hands, or Fingers R / L
__Neck Pain/Stiffness R/L
__Shoulder R / L
__Wrist/Hand R / L

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__Impotence
__Inability to Control Urine

WOMEN ONLY
__Breast Implants
__Hot Flashes
__ Irregular Cycle
__ Painful Periods
__ Pregnant
Due ____/____/_____
__Taking Birth Control
__Last Menstrual Cycle
____/____/_____

CARDIO-VASCULAR
__Chest Pain
__Heart Attack
__High/Low Blood Pressure
__Light Headed(Positional)
__ Pacemaker
__ Shortness of Breath
__Strokes
__High Cholesterol

RESPIRATORY
__ Allergy
__Asthma/Wheezing
__ Chronic Cough

EYE/EAR/NOSE/THROAT
__ Ear Ache/Infections
__ Ear Ringing
__ Frequent Colds/Flu
__Sinusitis/Hayfever
__ Sore Throats
__ Tonsillitis

MISCELLANEOUS
__ Loss of Bowel/Bladder Function
__ Night Pain
__ Numbing/Tingling in BOTH Arms and/or Legs
__Pain Wakes You From Sleep
__ Recent Infections/Night Sweats
__Unexplained Weight Loss
__ Vertigo
__ Motion Sickness

Height_____ Weight_____

FAMILY HISTORY

	Diabetes	Heart Disease	Cancer	Hypertension	Kidney Problems	Stroke
Mother (Age_____)	☐	☐	☐	☐	☐	☐
Father (Age_____)	☐	☐	☐	☐	☐	☐
Brother (# of _____)	☐	☐	☐	☐	☐	☐
Sister (# of _____)	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

☐ Smoking: Packs/Day_____ ☐Never Smoked ☐Past Smoker ☐Coffee: Cups/Day_____

☐ Soda: Cans/Day____ ☐ Alcohol: Drinks/Day___ ☐ Exercise type_____

☐ Nutritional Supplements Taken_____

_____

Symptom Survey

List problems from most severe to least severe. Please be as specific as possible.

Problem #1._____

Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #2._____

Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

Problem #3._____

Location of pain:_____
Severity of pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable) Pain is? Mild Moderate Severe
Progression (circle): same better worse How often is the pain present? Constant 50-75% 25-50% less than 25%
When did you notice the problem? _____ What happened? _____
Better with (circle): rest ice heat stretching exercise pain relievers topical creams other_____
Worse with (circle): sitting standing walking bending twisting lifting movement other_____
Quality of pain (circle): sharp shooting dull ache burning stiff stabbing throbbing numb sore
Does your pain radiate (example: travel into arms, legs etc.) Yes No Where? _____
What time of day is your problem the worse (circle): morning afternoon evening during sleep
What treatment have you received for this condition: medication physical therapy surgery chiropractic
other_____ Did it help? Y N

#4. Additional Complaints (use back of sheet if needed)

_____
_____
_____
_____
_____
_____
_____

Terms of Acceptance

The goal of our office is to enable patient to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you. Please read below and if you have any questions please feel free to ask one of our staff members.

INFORMED CONSENT

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it know, or to learn through healthcare procedures whatever he/she is suffering from a latent pathological defect, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a chiropractor at Heartland Family chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment, will be explained to me upon my request. It is understood and agreed that the amount paid to the doctor for x-ray's is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependents behalf in full or according to insured contractual agreement. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

ACKNOWLEDGMENT

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

COMMUNICATION

May we leave messages on any answering device, i.e. home answering machines or voicemails? ☐Yes ☐ No

MISSED APPOINTMENTS

There is a possible $20 fee charged for all appointments that are not cancelled prior to scheduled visit.

I, _____, have read and fully understand the above statements. I hereby attest that the information and health history I have provided is complete and accurate. I understand the importance of providing a truthful health history in order to assist the doctor in providing the best chiropractic care possible.

Print Name:_____

Signature:_____Date:_____

CONSENT TO TREAT A MINOR

Parent Signature:_____Date:_____