

Name _____ Date of Birth _____ **Health History Page 2**

What treatment have you received for your condition? Medication Surgery Physical Therapy Other _____

Are you Pregnant? Yes No N/A Due Date _____

Injuries & Surgeries you have had:

- **Falls** _____
- **Head Injuries** _____
- **Dislocations** _____
- **Broken Bones** _____

Circle those that you have or have had:

Abdominal pain Abuse, Survivor AIDS/HIV Alcoholism Allergy Shots Anorexia Appendicitis Asthma Athletes foot Auto Immune Disease Bleeding Disorder Blood clots Breast lump Bronchitis Bruising Bulimia Bursitis	Cancer (type _____) Chicken Pox Constipation Diverticulitis Diabetes Dislocation Emphysema Epilepsy Fibromyalgia Fractures Goiter Gout Heart disease Hepatitis Hernia	Herniated disk Herpes High Blood Pressure Inflammation Irritable Bowel Syndrome Kidney Disease Liver Disease Measles Migraines Miscarriage Mononucleosis Muscle Spasms Muscle Tear Multiple Sclerosis Mumps Numbness Osteoporosis Pace Maker	Parkinson's Pinched nerve Pneumonia Polio Rheumatoid arthritis Sciatica Scoliosis Thyroid Problems TMJ Tuberculosis Tumors/growths Turrets Syndrome Ulcers Venereal disease Varicose Veins Whiplash Other _____
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Exercise <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily What type: _____	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	Habits <input type="checkbox"/> Smoking Packs/Day _____ <input type="checkbox"/> Alcohol Drinks/Week _____ <input type="checkbox"/> Coffee/Caffeine Cups/Day _____ <input type="checkbox"/> High stress Reason _____ <input type="checkbox"/> Other _____
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Medications	Allergies	Vitamins & Herbs

HEBERLE CHIROPRACTIC

2010 PATIENT UPDATE

Please complete this form.
If there have been no changes then mark the box for that section.
Please SIGN the consent.

Patient Consent

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I have been informed by you of your NOTICE OF PRIVACY PRACTICES contain a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

SIGNATURE: _____

Relationship to Patient: _____

Patient Information

Today's Date ____/____/____

Name _____

Address: _____

City _____ St _____ Zip _____

Home (____) _____ Cell (____) _____

Work (____) _____

Date of Birth ____/____/____

Email _____

Marital Status _____

Occupation _____

Employer _____

Insurance Carrier _____

Subscriber Name _____ DOB ____/____/____

Subscriber Number _____

Primary Doctor/Clinic Name _____

Address: _____

City _____

Dr. Phone # (____) _____ Fax (____) _____

Date of Last visit ____/____/____

Do you have any questions about chiropractic? yes no

Thank you for taking a few minutes to fill this form out- it will be used to comply with the insurance company's record keeping

Accident Information

Is this condition caused by an accident? Yes No

Type: Auto Work Home Other _____

Date of accident ____/____/____

Insurance Co. _____

Claim Number _____ Adjuster _____

Whom have you reported the accident to:

Auto ins Employer Work Comp Other

SIGN HERE

Patient Condition

Please tell what hurts _____

Is it on right left both?

Does it travel? Yes No. To where? _____

On a scale of 1 to 10 what is your pain? _____

How long has it bothered you?

____ Day(s), week(s), month(s)

a long time not sure.

Have you seen any one for it? yes no

Does the pain feel? aching dull sharp other

How did it start? gradually all of sudden not sure

How often does it occur?

0%-25% 25%-50% 50%-75% 75%-100%

Have you had this before? yes no

I did this at rest during exertion no idea

The Symptoms are greatest

at night in the morning no change

What makes the pain better? _____

What makes the pain worse? _____

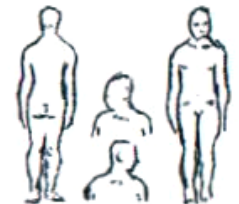
Please Mark the Diagrams with the following:

X :: Pain

= :: Spasm

/// :: Tingling/Numbness

→:: Radiating pain



Is there any other medical concerns you may have?

yes no . If so, please describe
