Welcome to Heath Chiropractic Clinic & Wellness Center LLC

1013 Ritner Highway Shippensburg, PA 17257 (717)530-5555

14 W. Main St. Landisville, PA 17538

Please fill out this confidential health form as completely as you can. The more information you provide us, the better we will be able to help you. If you have any questions or need any assistance in filling out these forms, do not hesitate to ask one of our qualified chiropractic assistants for help.

Today's Date:__/__/____ Whom may we thank for referring you to our office?_____

PERSONAL HISTORY _____

Last Name:_____ First Name:_____MI:_____

Address:_____ __ City:_____ State:_____

Zip Code:_____ Home Phone: (___)_____-_____Cell Phone (___)____-_____ Please provide us with your email for appointment/Health class/Health Newsletter Updates Email:_____

Birth Date:_____/_____/_____ Age:_____ Gender: F / M Marital Status: S / M / D / W /

Social Security Number:_____-_____-_____

_____

Employer:_____ Type of Work:_____

Zip Code:_____ Work Phone (___)____-_____

Spouse's Name:_____ Work Place:_____ ___ Phone:(___)____-_____

Name & Ages of Children (if applicable):_____

In an emergency, whom do we contact?_____ Phone:(___)____-_____

_____

CURRENT HEALTH CONDITIONS_____

Primary Health Complaint(s):_____

How long have you suffered with this problem?_____

How often does this problem currently bother you?_____

Does anyone else in your family have the same or similar problem(s)? YES / NO

If work related, has the accident been reported to your employer? YES / NO

If auto related, what is the date and time of the accident?_____

What other health practitioners have you consulted for this/ these complaints?_____

_____

Have you become discouraged that this problem has not been resolved? YES / NO

When the problem is at its worst, how does it make you feel?_____

When this problem is at its worst, how does it interfere with your:

Work?_____ Family life?_____

Recreation/Hobbies?_____

What effect is this problem having on other people in your life?_____

What effect is this problem having on your level of stress?_____

What daily habits do you have that could make this ?_____

On a scale of 1-10 (ten highest) rate your commitment to getting rid of this problem:_____

Is getting rid of this problem, and what caused it, a top priority for you?_____

PAST HEALTH HISTORY_____

Surgeries/ Operations: Appendix _____Tonsils_____ Hernia_____ Spinal_____ Cosmetic_____ Other:_____

Major accidents or falls since birth:_____

Hospitalizations (other than the above):_____

Please list all medications you presently take: (please include all medications, including over the counter and vitamins):_____

_____

_____

Are you currently under the care of a physician? YES / NO If yes, please indicate for what condition:_____

_____

Have you had previous chiropractic care? YES / NO Please list doctor's name and approx. date of last visit:

_____

Are you presently under the care of any other healthcare practitioners? Acupuncturist / Massage Therapist / Nutritionist / Other: _____

Please check any of the following conditions that you have had in the past:

__ Pneumonia __Tuberculosis __ Rheumatic Fever __ Mumps __Arthritis

__Thyroid Disorder __ Small Pox __Influenza __Eczema/Psoriasis

__Heart Disease __Polio __Whopping Cough __Measles __Cancer

__Pleurisy __Anemia

Scientific studies are now showing that repeated exposure to the above items can be extremely hazardous to your health. Your doctor will discuss with you ways to reduce your exposure to these harmful elements.

MENTAL/EMOTIONAL HEALTH HISTORY

Scientific studies are now showing that emotional stress has a great deal to do with an individual's health. Please answer the following questions as accurately and completely as possible:

Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could imagine and 1 being relatively no stress.

Please circle the appropriate number:	Low									High
Financial/ Money matters	1	2	3	4	5	6	7	8	9	10
Relationship / Family	1	2	3	4	5	6	7	8	9	10
Job/ Career/ Education	1	2	3	4	5	6	7	8	9	10
Current level of health	1	2	3	4	5	6	7	8	9	10
Spiritual/ Religious/ Ethical	1	2	3	4	5	6	7	8	9	10
Overall level of life stress	1	2	3	4	5	6	7	8	9	10

Please check all of the following life events that you are currently (or previously) experience stress with:

___ Birth of Siblings __Toilet training __Babysitters __Death of a pet
__ First year of school __Teachers __ Peer relationships __Onset of Puberty
__ Any betrayal __ Marriage __Moving __ Fights
__ Romance/dating __Illness/operation __ Accidents __ College
__ Parental conflict/separation __ Divorce __ Prom
__Abortion/miscarriages __Loss of job/layoff __Financial disruptions __Illness of a loved one
__Diagnosis of a fatal condition __Death of a loved one

Dr. Heath at Heath Chiropractic Clinic and Wellness Center is a specialist in NET (Neuro-emotional technique). He is able to determine through this method if stress is affecting your present condition and overall health. He will discuss this with you in your consultation. If Dr. Heath can show you how your health can improve and

your level of stress can be dramatically reduced, would you be interested in learning about this technique? YES / NO _____

SENSITIVE HEALTH INFORMATION

The following items have been listed as sensitive health information and, therefore, will never be copied or released. Even though they are sensitive, they are still vital to the effective management and care of your case. Please complete as accurately as possible.

1) History of alcohol use/abuse: YES / NO If yes, how much, what kind, and for how long have you consumed these?_____
2) History of recreational drug use/abuse? YES / NO If yes, what kind, how much, and how long?_____
3) Have you been diagnosed with a mental illness? YES / NO Diagnosis?_____When?_____
4) Have you ever been tested for HIV Virus? YES / NO Results? _____
5) Have you ever been diagnosed with HIV or an HIV related illness? YES / NO If yes, what type of treatment are you under? _____

Do you have allergies? YES / NO If yes, what kind?_____
Do you smoke cigarettes, cigars or chew tobacco? YES / NO If yes, how much?_____
Do you drink alcohol? YES / NO If yes, how much? _____
Do you drink coffee? YES / NO If yes, how much? _____
Do you drink soda/ soft drinks? YES / NO If yes, how much? _____
Do you eat fried foods? YES / NO If yes, how much/often?_____
Do you use white sugar/ artificial sweeteners? YES / NO If yes, how much/ often?_____

GOALS FOR YOUR CARE

We would like to thank you for choosing our office for your chiropractic and healthcare needs. It is our primary goal to provide the highest level of health care available. At Heath Chiropractic Clinic and Wellness Center, we know that people see chiropractors for a variety of reasons. Some go just for pain relief; some go further by wanting to correct the cause of their pain/symptoms as well; and others go even further by choosing complete health and wellness by correcting all means of dysfunction going on in their bodies even before any symptoms are present.

Please check the type of care desired so that we can best serve your health needs.

- □ **Relief Care**: Pain/Symptom relief only
- □ **Corrective Care**: Correction of the CAUSE of the pain/symptoms as well as relief of pain/ symptoms.
- □ **Comprehensive Care**: Bring all areas of the body that are malfunctioning to the highest state of health possible, while correcting the cause and providing pain/symptom relief to the areas of complaint.
- □ **I want the doctor to select the type of care appropriate for my health and condition.**
- □ **Initials: _____ Date:_____**

Your doctor will be making specific dietary recommendations and prescribing an individual supplementation program just for you. Please rate , on a scale of 1-10 (with 10 being the highest), your willingness to follow the recommended dietary and nutritional supplementation program._____

ERGONOMIC HEALTH HISTORY

How you treat and support your body on a daily basis has a direct impact on your health. Please help us help you by providing us with the following information:
Exercise Habits. Do you currently exercise?_____
Do you wear orthotics/ foot/ shoe inserts?_____
Your doctor may recommend a cardiovascular, strength training, and/ or stretching program. Please rate, on a scale of 1-10 (with 10 being the highest), your willingness to incorporate the prescribed exercise into your health care program. 1 2 3 4 5 6 7 8 9 10

SLEEP HABITS

What is your most common sleep position BACK / SIDE / STOMACH
Do you use a pillow ? YES / NO What type? REGULAR / CERVICAL (NECK)
What type of mattress do you sleep on and how old is it?_____
How many hours of sleep do you average per night? _____

WORK HABITS

How many hours per day are you:
Sitting :_____ Lifting:_____ Standing:_____ Crouching or bending over:_____
Walking:_____ Working at a computer:_____

Electronic Radiation Exposure:
Do you use any of the following daily? Circle all that apply.

Blow dryer/ curling iron	Microwave	Sleep within 3 feet of an electrical outlet
Cell phone/ cordless phone	Electric razor/toothbrush	Spend more than 1 hour per day in the car

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CONFIDENTIALITY AGREEMENT

TO OUR VALUED PATIENTS

We at Heath Chiropractic Clinic & Wellness Center have always made your privacy one of our top priorities. **We would like to inform you of the measures our office has taken to ensure your rights of patient privacy (in accordance with HIPPA)**

We communicate with our patients through mail, email, and by phone. Below is a list of how we correspond with you. Please indicate any items that you do NOT wish to receive:

MAILERS	PHONE CALLS	IN OFFICE (BOARD)
Birthday greetings	Health care maintenance reminders	Thank you for referrals board.
Healthcare maintenance reminders.	Missed appointment rescheduling	
Thank you cards for your referrals		
Health Newsletters		

In the event that we are unable to speak with you directly, please indicate ALL the ways that are acceptable for us to leave a courtesy message for you:

- □ On your home /cell phone answering machine or with your family.
- □ Office voicemail or with the receptionist.

We will do our best to honor your requests when communicating with you.

Yours in Health,

Dr. Heath and staff at Heath Chiropractic Clinic and Wellness Center

_____	_____	_____	_____
Patient Signature	DATE	WITNESS	DATE

I hereby authorize the doctor to provide me with a consultation and examination in order to determine if my case can be helped by chiropractic and the care provided here at Heath Chiropractic Clinic & Wellness Center.

I also understand that other exams and tests such as X-rays, lab tests, etc. may be necessary to gain more information regarding my health. I understand that if I am accepted as a patient here at Heath Chiropractic Clinic & Wellness Center, the doctor will discuss with me which course of care would be best for my case.

_____ _____
Patient Signature Patient Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

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Please put a check mark by any of the following that you have had in the past six months:

Musculoskeletal
Low Back Pain
Pain in the shoulders
Neck Pain
Shoulder/arm/wrist pain
Hip/Knee/ Ankle pain
Joint pin/ Stiffness
Difficulty walking
Jaw/Heat pain

Nervous System
Cold/Tingling extremities
Numbness/ loss of sensation
Dizziness
Seizures
Paralysis

Nervousness/Stress

Cardiovascular
Chest Pain
Shortness of breath
High blood pressure
Irregular heart beat
Stroke
Lung congestion
Varicose veins
Ankle swelling
Lung symptoms

General
Allergies
Fatigue
Loss of sleep
Unexplained fevers
Headaches

Gastrointestinal
Poor Appetite/ underweight
Excessive Thirst
Frequent nausea
Vomiting
Diarrhea
Constipation
Hemorrhoids
Liver Problems
Colitis/Chron's/ IBS
Gall Bladder problems
Abdominal Cramps
Gas/bloating after meals
Heartburn
Blood in Stool

Male Only
Prostate dysfunction
Loss of libido
Sexual dysfunction

Women Only
Menstrual Cramps
Irregular/ absent periods
Vaginal pain/ infection
PMS
Loss of libido
Menopausal symptoms
Breast Pain
Uterine/ ovarian fibroids
Date of last period ____/_____/_____
Are you pregnant? YES / NO / Not sure

Genitourinary
Painful/ excessive urination
Discolored urine
Bladder infections
Urinary leakage

EENT
Vision Problems
Dental problems
Earache/infections
Difficult hearing
Ringing in Ears
Cold/ Flu often
Sinus problems
Sore throat

Other Health Issues
_____
_____
_____
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_____

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OUR OFFICE POLICIES

Payment Policy

Our office is not affiliated with HMO's, PPO's or Health / Medical insurance companies. Patients who carry any form of medical or health insurance should know that all services rendered by this office are charged directly to the patient.
Payment in full is due at the time of service. This office does not carry balance. If payment is not received, the office uses outside sources to collect balances due.
Initials _____

Nutritional Supplements/ Health Supplies/ Test Kits

Nutritional supplements, Test kits and other health supplies MUST BE PAID FOR at the time of service.
Initials_____

Returned Checks

There will be a $20.00 charge on all returned checks. If multiple checks are returned during the course of your care, check privileges will be revoked. Future payment of your account will only be accepted in cash or credit card. Initials _____

Missed Appointments

Unless the office is given a 24 hour notice of cancellation for an appointment, you will be charged for the following for each appointment:
A regular $25.00
Extended office visits: Half of the visit price.
Initials _____

ANY QUESTIONS YOU HAVE REGARDING OUR POLICIES ARE WELCOME AT ANY TIME.

_____ _____

Patient Name **Date**

_____ _____

Patient Signature **Witness / Date**