Name_____ DOB_____ **Health History** Heberle Chiropractic Page 2

Circle those that you have or have had:

Abdominal pain	Eating Disorders	Muscle Tear
Abuse, Survivor	Emphysema	Multiple Sclerosis
AIDS/HIV	Epilepsy	Mumps
Alcoholism	Female Issues	Numbness
Allergy Shots	Fibromyalgia	Osteoporosis
Appendicitis	Fractures	Pace Maker
Asthma	Goiter	Parkinson's
Athletes foot	Gout	Pinched nerve
Auto Immune Disease	Heart disease	Pneumonia
Bleeding Disorder	Hepatitis	Polio
Blood clots	Hernia	Rheumatoid arthritis
Breast lump	Herniated disk	Sciatica
Broken bones	Herpes	Scoliosis
_____	High Blood Pressure	Stroke/ TIA
Bronchitis	High Cholesterol	Thyroid Problems
Bruising	Inflammation	TMJ
Bursitis	Irritable Bowel	Tuberculosis
Cancer	Syndrome	Tumors/growths
(type_____)	Kidney Disease	Ulcers
Chicken Pox	Liver Disease	Venereal disease
Constipation	Measles	Varicose Veins
Diverticulitis	Migraines	Whiplash
Diabetes	Miscarriage	Other
Dislocations	Muscle Spasms	_____

Exercise

[] None
[] Moderate
[] Daily
What type:
_____

Habits

[] Smoking
Packs/Day_____
[] Alcohol
Drinks/Week_____
[]Coffee/ caffeine/ day
[]Other

Medications/ supplements

Falls/ injuries

Work Activity
[] Sitting
[] Standing
[] Light Labor
[] Heavy Labor

Allergies

Surgeries

Thinking about the last 2 weeks- please mark your response to the following questions

My Back pain has spread down my legs at some time in the last 2 weeks [ ] DISAGREE [ ] AGREE
I have had pin in the shoulder or neck at same time in the last 2 weeks [ ] DISAGREE [ ] AGREE
I have only walked short distances because of my back pain [ ] DISAGREE [ ] AGREE
In the last 2 weeks, I have dressed more slowly than usual because of back pain [ ] DISAGREE [ ] AGREE
It's not really safe for person with a condition like mine to be physically active [ ] DISAGREE [ ] AGREE
Worrying thoughts have been going through my mind a lot of the time [ ] DISAGREE [ ] AGREE
I feel that my back pain is terrible and its never going t get any better [ ] DISAGREE [ ] AGREE
In general, I have not enjoyed all the things I used to enjoy [ ] DISAGREE [ ] AGREE
Overall, how bothersome has your back pain been in the last 2 weeks?
[ ] NOT AT ALL [ ]SLIGHTLY [ ]MODERATLEY
[ ]VERY MUCH [ ]EXTREMELY

I've had little interest or pleasure in doing things [] not at all [] several days [] more than half the days [] nearly every day
Feeling down, depressed or hopeless [] not at all [] several days [] more than half the days [] nearly every day
Trouble falling or staying asleep, or sleeping too much [] not at all [] several days [] more than half the days [] nearly every day
Feeling tired or having little energy [] not at all [] several days [] more than half the days [] nearly every day
Poor appetite or overeating [] not at all [] several days [] more than half the days [] nearly every day
Feeing bad about yourself- or that you are a failure or have let yourself or family down [] not at all [] several days [] more than half the days [] nearly every day
Trouble concentrating on things such as reading the newspaper or watching television [] not at all [] several days [ ] more than half the days [ ] nearly every day
Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than normal than usual [] not at all [] several days [] more than half the days [] nearly every day
Thoughts that you would be better off dead or of hurting yourself in some way [] not at all [] several days [] more than half the days [] nearly every day

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people
[] not difficult at all [] somewhat difficult [] very difficult [] extremely difficult

Heberle Chiropractic

2024 Patient Update

Patient Information

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

Today's Date _____/_____/_____

Name_____

Address:_____

City_____State_____Zip_____

Primary Phone (_____) _____

Emergency contact and phone number

_____ (_____) _____

Date of Birth _____/_____/_____

Email_____

I understand my email will be used to inform me of events at Heberle Chiropractic
[ ] Yes [ ] No

Marital Status_____

Occupation_____

Employer_____

Insurance Carrier _____

Subscriber Name_____ DOB ____/____/_____

Subscriber Number_____

How did you hear about the office? [ ] Friend/family

[ ] Doctor [ ] internet search [ ] Other

I have not had any symptoms of COVID 19 and /or been exposed to anyone with a positive test in the last 2 weeks [ ] yes [ ] no

I am fully vaccinated for COVID 19 [ ] yes [ ] no

Primary Doctor/Clinic

Name _____

Address:_____

City_____

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

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

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 treatment have you received for your condition?
[]Medication []Surgery []Physical Therapy []
Other

What do you want to do that the pain stops you from doing?

_____

What makes the pain better?

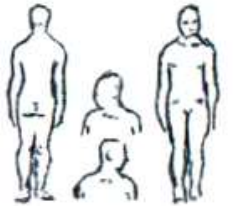
_____

What makes the pain worse?

_____

Please Mark the Diagrams with the following:

X :: Pain
= :: Spasm
/// :: Tingling/Nur
→:: Radiating pa



Is there any other medical concerns you may have?
[ ] yes [ ]no . If so, please describe

_____

_____

_____

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

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 heath care providers who may be involved in that treatment directly or indirectly
- Obtain payment form 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 re 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: _____