Please check the type of care desired so that we may be guided by your wishes when possible:

☐ Temporary relief ☐ Control of immediate problem

☐ Preventive health care ☐ I prefer the doctor select the type of care she feels is best for me.

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? _____Yes _____No

Do you have Health Insurance? _____Yes _____No If yes, Policy # _____

Name of Company _____Agent's Name _____

Are you covered by Medicare? _____Yes _____No

If yes, Health Insurance # _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____Date: _____

Doctor's Signature: _____

FAMILY HEALTH INFORMATION.

(Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us a better understanding of your total health picture.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

FOR OFFICE USE ONLY: ☐X ☐Open X ☐Y Classification_____

CONFIDENTIAL PATIENT CASE HISTORY

Heaney Family Chiropractic

Dr. Maggy Heaney
Dr. Sean Heaney
Chiropractors

Case No._____

Dear patient:
Please complete this form. Your answers will help us determine if chiropractic can help you.
THANK YOU.

Name: (Please Print) _____Date: _____

Address: _____City_____State_____Zip_____

Previous Address if less than 3 years: _____

Telephone: (home) _____ (work) _____

Age: _____ Date of Birth: _____ Sex: _____Marital Status: ☐S ☐M ☐W ☐D

Occupation: _____S.S. # _____

Driver's License #: _____Employed By: _____

Address _____Spouse's Name: _____

Children: _____Ages: _____

Referred to Heaney Family Chiropractic BY: _____

IF PATIENT IS A MINOR:

Parent's Address: _____

Who is financially responsible for this bill? _____

Signature of Guardian or Parent authorizing care: _____

HEALTH INFORMATION:

What is your major complaint? _____

_____

_____

Other complaints: _____

_____

How long have you had this condition? _____

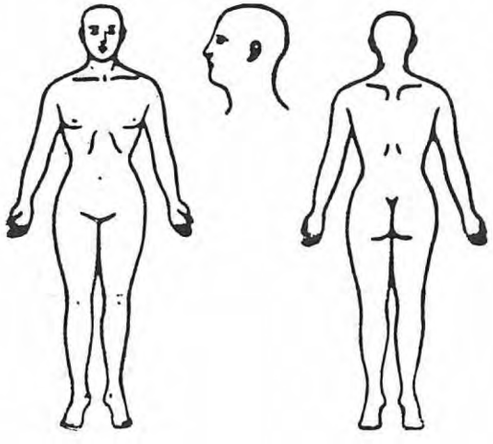
Have you had this or similar conditions in the past? _____ _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Constant ☐Comes and goes

Please mark your areas of pain on the figures shown:

Comments:



Is this condition interfering with your: ☐Work ☐Sleep ☐Daily routine ☐Other _____

How long has it been since you really felt good? _____

Other doctors who treated this condition _____

_____

Are you now or do you have any reason to believe you may be pregnant? ☐Yes ☐No

Date of last x-ray and description (including dental) _____

List surgical operations and years: _____

_____

Drugs you now take: ☐Nerve pills ☐Pain killers ☐Muscle relaxers ☐"Pep" pills ☐Tranquilizers ☐Allergy ☐Insulin ☐Birth control pills ☐Others_____

Vitamins you now take: _____

Age of mattress_____ ☐Comfortable ☐Uncomfortable

Age of water bed_____ ☐Comfortable ☐Uncomfortable

Sleeping Habits: BACK — ☐Always ☐Sometimes ☐Never
SIDE — ☐Always ☐Sometimes ☐Never
STOMACH — ☐Always ☐Sometimes ☐Never

Are you wearing: ☐Heel lifts ☐Sole lifts ☐Inner soles ☐Arch supports

Have you been in an auto accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐Never

Describe:_____

Have you had any other personal injury or accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐None

Describe:_____

Date of last physical examination: _____

How often do you have any of the following: (use 1, 2, or 3)

1-NEVER 2-PREVIOUSLY 3-PRESENTLY

NERVOUS SYSTEM

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

MUSCULO-SKELETAL SYSTEM

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken bones

ACTIVITY INFORMATION

Sports you are now or have been involved in:

	Presently	Past 5 Years	Over 5 Years	Never
Jogging/Running				
Weight lifting				
Racquet ball/Hand ball				
Tennis				
Football				
Soccer				
Skiing				
Others				

Exercises you are presently doing: _____

_____

What do you know about your own birth process? _____

☐Home Birth ☐In Hospital ☐Cesarean ☐Forceps ☐Mid wife in attendance ☐Other

Complications (if any) _____

Do you now smoke: ☐Cigarettes ☐Cigars ☐Pipe How long? _____

(over)