

Danita Thomas Heagy, DC, LLC
4425 US-1 South, Suite 109
St. Augustine, FL 32086

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Work Address: _____

Date of last Chiropractic check-up _____ Name of Chiropractor _____

Present medication _____

List any surgeries since your last visit _____

Any other doctors consulted _____

Any accidents since your last visit _____

Current athletic activities in which you regularly participate _____

Any other pertinent information you feel important to your chiropractic visit

Do you smoke _____

For women only: Is there any possibility you are pregnant _____

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NAME _____

DATE _____

1. What is your objective in visiting us today?

_____.

2. If you have a health concern, when did this problem start? _____ (exact date or your best estimate)

A. What brought on this condition?

_____.

3. Have you ever had this condition before? Yes No

A. If yes, what originally brought on this condition?

_____.

4. Does anything make your condition worse or better?

_____.

5. If you have pain associated with your condition, how would you describe it?
(Check those that apply)

Sharp Constant Localized Radiating Pins & Needles
 Dull Comes & Goes Diffuse Numbness Burning

6. If you are having pain or numbness, where is the exact location?

_____.

7. Is there any time of the day or any activity that makes your condition worse?

better? _____.

8. What are your health care goals?

_____.

9. Do you have an insurance that covers Chiropractic care? _____
Name of insurance company _____.