

Dr. Danita Thomas Heagy, DC, LLC

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WELCOME! Thank you for choosing this office to assist you with your health care. Once the exam is complete, I will present my findings and recommendations to you briefly. At the Health Dialogue, we will review the findings in detail as well as make recommendations for home care and chiropractic care so that you can get the best results. To begin this process, please provide your basic background information by completing the following questionnaire.

Pay special attention to the section "Reasons for Consulting the Office". Please answer all questions and when there are "none" or "not applicable" please indicate this. Again, welcome to our office.

Date _____ Cell Phone _____

Name _____ Home Phone _____

Email Address _____ Work Phone _____

Mailing Address _____ City _____ State _____ Zip Code _____

Age _____ Birth Date _____ Marital Status S ___ M ___ W ___ D ___ Height _____ Weight _____ #Children _____

Occupation _____ Employer _____

Name of Spouse/Nearest Relative _____ Occupation _____

Employer _____ Work Phone _____ Home Phone _____

Referred by _____

Present family doctor _____ Address _____

Date of last physical examination _____ By Doctor _____

While we do not accept insurance assignment, we would like to be made aware if you have:

_____ Medicare? _____ Insurance that might cover chiropractic care?

PREVIOUS CHIROPRACTIC CARE?

Yes _____ No _____ Date of last adjustment _____ Name of Chiropractor _____

Were x-rays taken? Yes _____ No _____ Have you ever received wellness care? _____ If yes, when? _____

Please read the following carefully, then sign and date it. Thanks!

MY RESPONSIBILITY

My responsibility to you is to provide the best chiropractic care possible, to give you information so that you can better care for your health.

YOUR RESPONSIBILITY

Your responsibility is to learn, by participating in our patient education program, to ask questions, and make informed decisions about the recommendations I make for your care. You are also responsible for keeping your schedule of care and for payment for your care. Payment is due at the time of services unless you have made specific previous financial arrangements with me. Please inform me if you have insurance that covers chiropractic care; although I do not accept assignment, I will provide you with the necessary paperwork for you to send to your provider for reimbursement. If you have an accident, surgery, a change of address or any other changes in your history, please advise on the visit following the change.

YOUR CARE

The chiropractic adjustment is a quick movement of the vertebrae of the spine, for the purpose of specifically realigning the bone(s) of your spine to maximize the function of your nervous system. Most patients say that the adjustment is comfortable, others may be sore the day after the adjustment. The risk of injury during an adjustment is very small. The risk of having a subluxation and receiving no care includes degeneration of the affected area and nerve compromise, which affects the health of your entire body. Ongoing research states that with early intervention, the vertebral subluxation complex can be eliminated. If degeneration occurs, the prognosis for full recovery decreases significantly.

TERMS OF ACCEPTANCE

When a person seeks chiropractic care and when a chiropractor accepts that person as a patient, essential to the success of the relationship is that both parties seek the same goals. **My sole intent and goal as a chiropractor is to find and correct the vertebral subluxation complex, to assist you in attaining your optimum health.** I do not treat or cure any physical, mental or emotional ailments nor diagnose or give advice about ailments or diseases. This is because I know that your body is self-healing and self-regulating and that, when freed from the effects of the subluxation, it has the innate ability to heal itself and maximize the function of your nerves, allowing better communication between your brain and your body. If I find that medical co-management is necessary, I will advise you of that.

ACKNOWLEDGEMENT

I have read and understood this and agree to its terms and intent.

Patient's signature _____ Date _____

Parent/guardian signature (if patient is under 18) authorizing care

_____ Date _____

PRESENT REASON FOR CONSULTING OUR OFFICE (check all that apply)

_____ I have no special problem; I understand the role of chiropractic in my general health care and the importance of regular spinal check-ups.

_____ I have a DISEASE/SYMPTOM (circle one) and I am interested in help with this specific problem; in addition I am interested in learning about my Health Potential and the role of chiropractic in improving my family's health.

_____ I have a DISEASE/SYMPTOM (circle one) and I am interested in help with this problem and in learning how to prevent it in the future.

_____ I have a DISEASE/SYMPTOM (circle one) and I am only interested in help with this specific problem.

LIST DETAILS OF ANY EARLY TRAUMA:

YOUR Birth (if you know) Length of mother's labor ___hrs. Were you born at home___or in the hospital ___?

Drugs used during delivery? Yes___No___Forceps/Force?___Were you in the normal position for delivery? Yes___No___

If no, what position_____ Drugs taken during pregnancy? _____

Did/Do you play contact sports? Yes___ No___

ANY SIGNIFICANT FALLS OR ACCIDENTS AS A CHILD? PLEASE LIST:

- 1. _____ When_____
- 2. _____ When_____
- 3. _____ When_____
- 4. _____ When_____

AS AN ADULT?

- 1. _____ When_____
- 2. _____ When_____
- 3. _____ When_____
- 4. _____ When_____

LIST FRACTURES THROUGHOUT YOUR LIFETIME:

- What _____ When_____
- What _____ When_____

PLEASE LIST ALL SURGERIES YOU HAVE HAD:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Remarks _____

OCCUPATIONAL STRESSES:

Repetitive physical positions: _____

Heavy/Awkward lifting, explain: _____

Other: _____

How would you rate your current of emotional stress: (Lowest) 1 2 3 4 5 6 7 8 9 10 (Highest)

Do you deal with stress easily or with difficulty? _____

LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU TAKE CURRENTLY:

What _____ When _____

What _____ When _____

What _____ When _____

Do you consider yourself a healthy person? _____

Please explain why or why not: _____

Do you have health eating habits? _____

Do you exercise? _____ What type? _____ How often? _____

Do you smoke? _____ How much? _____ For how long? _____

Do you have any health habits you would like to change? Explain _____

FOR WOMEN ONLY: Is there any possibility that you are pregnant? _____ Date of last menses? _____

Is there any other pertinent information you would like to include here regarding your past or current health picture? _____

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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** started this condition?

_____.

4. 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

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

_____.

6. Is there any time of the day or any activity that makes your condition worse? –
better? _____

_____.

7. What are your health care goals?

_____.

8. Do you have an insurance that covers Chiropractic care? _____

Name of insurance company _____.

Danita Thomas Heagy D.C, L.L.C
"Life and Health Are Both Simple When You Go To Cause"

Health History:

Please check all the following health concerns that you have experienced, even if you do not think that your answers relate to your present health concern.

Circulatory/ Vascular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immune System Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mood Swings	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness/Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Digestive Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary Difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vertigo	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn/Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Stress History:

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health concerns.

1) Childhood

Repeated Prolonged Antibiotic Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Car Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inhaler Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Childhood Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a Height < 3 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaccination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a Height ≥ 3 feet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Youth Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No

2) Adulthood

Alcohol Consumption	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inhaler Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repeated/Prolonged Antibiotic Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prescription Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Car Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coffee Drinker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Use/ Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall/Jump from a Height	<input type="checkbox"/> Yes <input type="checkbox"/> No	Extreme Sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Workplace Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home Environment Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Traumas (physical or emotional):	
