

Dear New Patient,

I would like to extend a warm welcome to you. Once the examination procedures are completed, analyzed and correlated, I will present my findings and recommendations to you, providing you with the optimum in care and recommendations based on current scientific standards. This will require a basic background of knowledge that maybe new to you even if you have been to chiropractors in the past. So that you understand your "report of findings", you will be given educational materials that are designed to help you understand and achieve optimum spinal health.

Let's begin this health process with some basic information. Please fill out the "Patient Information" on the following pages, paying special attention to the section on "Reasons for Consulting the Office". Please answer all questions and when there are "none" or "not applicable" please indicate this. Again, welcome to my office.

Sincerely,

Danita Thomas Heagy, DC

Date: _____ Business Phone _____

Name: _____ e-mail: _____ Home Phone _____

Mailing Address _____ State _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital Sttus: S__M__W__D__ Height _____ Weight _____ # Children _____

Occupation _____ Employer _____

Name of Spouse/Nearest Relative _____ Occupation _____

Employer _____ Office Phone _____ Home Phone _____

Refereed by _____

Present family doctor _____ Address _____

Date of last physical examination _____ By Doctor _____

PREVIOUS CHIROPRACTIC CARE?

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

Were x-rays taken? Yes _____ No _____ Have you ever received wellness care? _____ When? _____

PRESENT REASON OF CONSULTING OUR OFFICE

- I have no special problem; I understand the role of chiropractic in my general health care & 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 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: Length of 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 _____
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 _____
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 level 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 healthy eating habits? _____

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

Do you smoke? _____ How much? _____ 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?

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

OUR RESPONSIBILITY

My responsibility to you is to provide the best chiropractic care possible and to educate you as to how to care for your spine, and how to keep it in top form, if you choose.

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 chiropractic care. You are also responsible for keeping your schedule of care once you have decided to accept our recommendations and you are responsible 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, a surgery, a change of address or any other changes in your history, please advise me 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. 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. These risks include fracture or in extremely rare instances, stroke can occur. Great controversy exists within the scientific community regarding the risk of stroke: some authors say that chiropractic care actually reduces the risk, others say that the risk is one in one million, to one in five million. 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 suggests 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. I do this 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. Your body functions at a much higher and more efficient level when I reduce the subluxation because the adjustment maximizes the function of your nerves, allowing for freer communication between your brain and your body.

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 _____

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):	

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St. Augustine, Fl. 32086
904-797-5100

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 _____.