**Heartland Chiropractic Clinic, P.C.**
**Sandra Kreber, L.Ac.**
**2418 Cornhusker Road**
**Bellevue, NE 68123 402-291-2121**

Number ______________________

Date _________________________

Name_________________________________________________________ Referred by _______________________

Address_______________________________________City____________________State _______ZIP ___________

Date of birth ______________________________ Marital Status: Single Married Divorced Other

Phone____________________________________ E-mail________________________________________________

Social Security Number____________________________ Cell phone______________________________________

Occupation_________________________________Employer_____________________________________________

Employer's Phone Number____________________________ How long worked there _________________________

Whom to contact in emergency_____________________________________Phone____________________________

Who is financially responsible for this bill?____________________________________________________________

Have you ever had acupuncture before? ______________________________

Have you seen someone for this condition?___________ if yes, who_______________________________________

Who is your primary care physician?_________________________________________________________________

What medicines are you taking? ____________________________________________________________________

What is your primary complaint? ___________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Is it constant, or does it come and go? _______________________________________________________________

Are you improving, same, or worse? _________________________________________________________________

What aggravates the problem? ______________________________________________________________________

When was the first time this condition was felt? ________________________________________________________

Have you ever had a similar condition? _______________________________________________________________

Can you think of anything that may have caused this? ___________________________________________________

What have you done to treat this so far? Did it help? ____________________________________________________

What normal activities has this interfered with? Sleep, standing, walking, sitting, etc. ___________________________

_______________________________________________________________________________________________

On a scale of 1 to 10 (ten highest), what is your commitment to get rid of this problem? _________________________

Have you been given a diagnosis for this problem(s)? If so, what?__________________________________________

**Habits**

Do you have a regular exercise program?______if yes, please describe________________________________________

Please indicate usage per day or per week:

Water ______________ounces per day
Coffee ______________ounces per day
Tea ______________day/week (circle)
Alcohol ______________day/week Type: liquor/beer/wine
Soft Drinks ______________day/week
Cigarettes ______________day/week
Sweets ______________day/week

Please describe your average daily diet: Be Specific.

Breakfast:________________________________________________________________________
Snack:____________________________________________________________________________
Lunch:____________________________________________________________________________
Snack:____________________________________________________________________________
Dinner:___________________________________________________________________________
Snack:____________________________________________________________________________

Supplements/herbs/vitamins/minerals: (Please list brand, product name, and reason for taking)

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

**Energy**

How is your energy? Please circle. Low 1 2 3 4 5 6 7 8 9 10 High

What time of day is your energy the highest? _______________________
Lowest?___________________________ Do you fatigue easily: Yes/No

**Emotions and Sleep**

How do you feel emotionally? (for example, do you feel well balanced with all emotions or is there a particular emotion you feel more than the rest)__________________________________________________________

Do you have (circle all of that apply):

Panic attacks Depression Anxiety Bad temper
Nervousness Fear attacks Poor memory Difficult concentration
Irritability Lack of joy in life

Are you in a relationship? _____Good/Fair/Bad
Stress: Yes/No if yes, High, Moderate, Low (circle)
How do you handle your stress?______________________________________________________
How do you relax?________________________________________________________________
Do you like your job? Yes/No
How many hours of sleep do you get each night? ___________________per night
I have difficulty with: (circle all that apply)

Falling asleep Staying asleep Dream disturbed Restless
Waking up at about_________ am/pm and not being able to fall back to sleep again

**Gastrointestinal**

I have (check all that apply):

| | | | | |
|---|---|---|---|---|
| Belching | Nausea | Vomiting | Ulcers | Bloating |
| Gas | Heartburn | Hernia | Acid Reflux | Stomach pain |
| Gall Bladder issues | | Liver issues | Diabetes | Difficult digestion |
| IBS | Colitis | Crohns Disease | | Weight loss (unexplained) |
| Weight gain (unexplained) | | No appetite | | Good appetite |
| Cravings for sweets/salty/both | | Increased appetite | | |

Bowel Movement: How often?________time(s)/day or ________every days/week

Color of stool:____________________

Shape of Stool: ____________________

I have (circle all that apply):

| | | | |
|---|---|---|---|
| Irregular Bowel Movements | Constipation | Diarrhea | Undigested food in stool |
| Burning sensation | Hemorrhoids | Itchiness | Painful bowel movement |
| Loose stool | Hard stool | blood in stool | |

**Urination**

How often do you urinate? _____ times per day. Color: Pale yellow/dark yellow/clear/orange

I have or had (circle all that apply):

| | | | |
|---|---|---|---|
| Trouble starting stream | Frequent urination | Incontinence | Dribbling |
| Burning | Pain | Blood in urine | Kidney stones |
| Urinary tract infections | other______________________ | | |

**Women only**

Are you pregnant or suspect you are pregnant? Yes/No

Age of first menses:________________

Date of last period: ____________________________

Number of flow days:_______________ Typical color: (circle) dark red/bright red/pale red/brownish red

Number of days between period: _____________days

I have or had (check all that apply):

| | | | | |
|---|---|---|---|---|
| Irregular menstruation | Heavy flow | Light flow | No flow | Clots |
| Vaginal itchiness | Spotting between period | | Discomfort/pain before period | |
| Headaches before/during/after period | | | Irritability | |
| Breast Tenderness | Cravings | Cramps | | |

Vaginal Discharge? Yes/No Color:_____________________

Number of pregnancies____________________ Number of children____________

Menopause:

Age of onset:_____________

Symptoms: Circle all that apply

| | | | |
|---|---|---|---|
| Night Sweats | Spontaneous Sweating | Hot flashes | Vaginal dryness |

Sex Drive:

| | | | |
|---|---|---|---|
| Low sex drive | High sex drive | No sex drive | Normal sex drive |

STD: Yes/No If yes, please list________________________________________

**Men**

I have (circle all that apply):

| | | | |
|---|---|---|---|
| Prostatitis | Impotence | Penis blood/mucous/discharge | Reproductive problems (low sperm) |
| Low sex drive | | High sex drive | No sex drive |

STD: Yes/No If yes, please list________________________________________

**Eyes, Ears, Nose, Mouth, Throat, and Head**

Do you smoke? Yes/No If Yes ____per day, for______ years.

I have (circle all that apply):

| | | | |
|---|---|---|---|
| Frequent colds | Chronic runny nose (PND) | Frequent sore throats | Chronic cough |
| Allergies (environmental/food) | | Coughing blood/mucous | Pain inhaling |
| Shortness of breath (on exertion/rest) | | Nose bleeds | Pain in eyes |
| Dry eyes | Redness of eyes | Poor vision/must wear glasses | See spots/floaters |
| Dizziness | Vertigo | Ear pain | |
| Ear ringing: high pitch/low pitch | | Asthma | Clogged ears/popping |
| Dry mouth | Bleeding gums | Odd taste in mouth | Dental issues |
| Hyperthyroidism/hypothyroidism | | goiters | jaw clicks |
| Jaw pain | Other______________ | | |

Headaches: Yes/No if yes circle all that apply: top of head, occipital region, behind eyes, temporal region, frontal area)

Sinus related: Yes/No if yes do you have nasal congestion? Yes/No

Migraine? Yes/No if yes, triggers that contribute to headaches_______________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

How often? _____time(s) per day/week/month

**Cardiovascular**

I have (circle all that apply):

| | | | | |
|---|---|---|---|---|
| Chest pain | Palpitation | Varicose veins | Cold hands and feet | Irregular heart beat |
| Poor circulation | | Hypertension | Hypotension | Edema (hands/ankle/feet) |
| Anemia | | Stroke, if yes when____________________ | | |
| Heart Attack if so when___________________ | | | Heart Disease | Other_________________ |

**Muscles/Bones/Joints**

Do you have pain or tightness? Yes/No If yes, please indicate the location_____________________________________________________________________________________________

______________________________________________________________________________________________

The pain is (circle all that apply):

| | | | | | |
|---|---|---|---|---|---|
| Sharp | Dull | Achy | Numb | Burning | Superficial Pain |
| Deep pain | Tingling | Shooting | Throbbing | Pain worse in am/pm | |
| Pain worse/better with heat | | | Pain worse/better with cold | | |
| Pain worse/better with pressure | | | | | |

I have (circle all that apply):

| | | | | |
|---|---|---|---|---|
| Swollen joints | Arthritis | Tendonitis | Muscle cramping/spasms | Muscle pain |
| Repetitive Strain injury | | Bone Pain | Fracture bone(s) Where?_______________________________ | |
| Tremors | Odd Sensations | | Paralysis | Bursitis |
| Muscle weakness | | Acute Muscle Strain | | |

Please explain any injury in the space provided:

Date of onset:__________________________________________________________________________________

Location:______________________________________________________________________

Duration of Pain:________________________________________________________________

Aggravating factors:_____________________________________________________________

Alleviating factors:_____________________________________________________________

Treatments: (chiropractic, medication, etc.):______________________________________________

**Skin and Hair**

I have or often have (circle all that apply):

Dry skin    Itchy skin    Acne    Rash    Eczema    Hives    Hair loss

Premature graying    Age spots    Bruising easily    Nails dry/brittle/weak

Other_________________

**General**

Have you ever had cancer or currently have cancer? Yes/No If yes, what kind of cancer?

______________________________________________________________________________

Are you receiving chemotherapy/radiation/other treatment? Yes/No if yes, list current treatment___________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list any other health history that you have experienced that may affect treatment:_________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

# Financial Policy:

- As a courtesy, we will bill your insurance company if you have acupuncture benefits. We cannot bill health insurance for conditions that are not covered by your plan so contact your insurance provider and find out what conditions they will provide coverage for. **You are expected to pay on the day of your service.** If we receive reimbursement for your treatment, they will be applied to your account as a credit or a check can be made out to you. Expect payment within 6-8 weeks of your first office visit. I am not a provider for any insurance company so your insurance provider will send you reimbursement for your visits. If we do receive a payment, as stated above you may choose to receive a check or to apply to your account.
- **A $45.00 fee will be charged for missed appointments or cancellation without a 24 hour notification.**
- Payment is due at the time of service.

**Patient Signature Consent for Treatment:** I consent to treatment. I understand that there can be side effects associated with acupuncture (bruising, minor bleeding, dizziness, etc.). I understand that acupuncture does not replace Western Medicine and that my acupuncturist will not diagnose my condition in terms outside her scope of practice and will refer to a western medical practitioner should it be necessary. I understand that acupuncture consists of using sterile needles and other stimuli to balance the meridians. I authorize the release of any medical information necessary to process this claim. I authorize payment of acupuncture benefits to the licensed acupuncturist for provided services. My signature indicates I have seen my MD within last 90 days or have a referral.

I understand that **regardless of my insurance status,** I am ultimately responsible for the balance on my account for professional services rendered. I certify that the information given is true and correct to the best of my knowledge.

Signature_______________________________________________ Date____________________________

Parent if minor___________________________________________ Date____________________________