Today's Date: ______________________

ABOUT THE PATIENT

Daniel Kiefat DC 2525 DeMers Ave. Ste B, Grand Forks, ND 58201 Chart #: ____________

Name: ________________ ____ ______________________ _____
First M.I. Last Suffix

Social Security #: ________-_______-_________

Address: ____

Birth Date: ______________ Age: ______ Gender: ❑M ❑F

City: ______________________ State: _______ Zipcode: _________

E-Mail Address: ____________________________________

Phone #s: Home: (_____)______-__________

Cell: (_____)______-__________

Work: (_____)______-__________

Employer: ______________________________________

Type of Work: ____

Emergency Contact: ____________________________ Relation: ______________________ Phone#: (_____)______-__________

Name of Medical Doctor(s) ____

How did you hear about hear about Heartland Clinic of Chiropractic? ❑Insurance Company ❑Phone Book ❑Internet/Website

❑Friend/Patient: ________________________ (Name) ❑Physician: __________________________ (Name) ❑Other: __________________________ (Please Explain)

❑Yes ❑No Have you been to a chiropractor before?

❑ I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
❑ I authorize the Heartland Clinic staff to request records from other providers as may be necessary.
❑ I understand that after any initial promotional services all care is rendered at usual and customary fees.

____ ____________________
Patient / Parent Signature Date

PAYMENT RESPONSIBILITY

❑YES ❑NO Do you have health care insurance? Insurance Company: ____
(Please give insurance card to front desk so that we may verify your chiropractic benefits.)

❑YES ❑NO Are your symptoms due to a car accident or work injury?
(Please notify front desk as we will need additional information to process your claims)

Insurance Company:___________________________________ Policy/Claim#: ______________________________

Injury Date: _____________________

REASON FOR SEEKING CARE

PRESENT COMPLAINTS - Please list each complaint on a separate line and check any boxes that applies to that complaint

1. ____ How long has this been an issue? ________________________
❑Dull ❑Sharp ❑Ache ❑Numb / Tingle ❑Stabbing ❑Constant ❑Occasional ❑Mild ❑Moderate ❑Severe
❑Staying the same ❑Getting worse ❑Worse in the morning ❑Worse in evening ❑ Pain radiates to __________________________

2. ____ How long has this been an issue? ________________________
❑Dull ❑Sharp ❑Ache ❑Numb / Tingle ❑Stabbing ❑Constant ❑Occasional ❑Mild ❑Moderate ❑Severe
❑Staying the same ❑Getting worse ❑Worse in the morning ❑Worse in evening ❑ Pain radiates to __________________________

3. ____ How long has this been an issue? ________________________
❑Dull ❑Sharp ❑Ache ❑Numb / Tingle ❑Stabbing ❑Constant ❑Occasional ❑Mild ❑Moderate ❑Severe
❑Staying the same ❑Getting worse ❑Worse in the morning ❑Worse in evening ❑ Pain radiates to __________________________

4. ____ How long has this been an issue? ________________________
❑Dull ❑Sharp ❑Ache ❑Numb / Tingle ❑Stabbing ❑Constant ❑Occasional ❑Mild ❑Moderate ❑Severe
❑Staying the same ❑Getting worse ❑Worse in the morning ❑Worse in evening ❑ Pain radiates to __________________________

- Do your symptoms affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving
  Other: ____
- What makes it better? ____
- What makes it worse? ____
- What Doctor's have you seen for this? ____
  ____
- Type of treatment: ____
- Results: ____
- Hobbies/Interests: ____

Please mark ALL areas of concern