Today's Date: _____

ABOUT THE PATIENT

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

Name: _____ ____ _____ _____ Social Security #: _____-_____-_____
First M.I. Last Suffix

Preferred Name if other than above:_____ _____ Birth Date: _____ Age: _____ Gender: ❑M ❑F

Address: _____ E-Mail Address: _____

City: _____ State: _____ Zipcode: _____

Phone Numbers Cell: (_____)_____-_____ ❑ **Text Me Appointment Reminders!** Cell Carrier:_____

Home: (_____)_____-_____ Employer: _____

Work: (_____)_____-_____ 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? _____

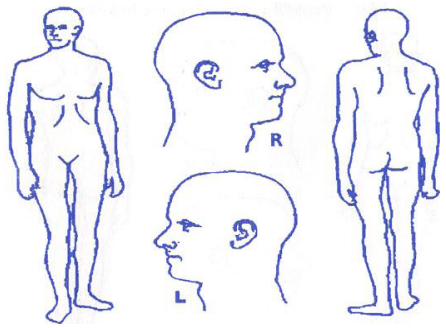
_____

• Type of treatment: _____

• Results: _____

• Hobbies/Interests: _____

Please mark ALL areas of concern



GENERAL HEALTH HISTORY

Daniel Kiefat DC 2525 DeMers Ave. Ste B, Grand Forks, ND 58201

Patient Name_____ Mark the conditions that apply to you.

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking: _____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____
5. List any past work injuries: _____ Was any care received? _____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____