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? _____

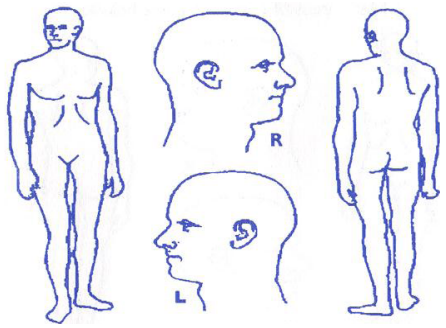
_____

• Type of treatment: _____

• Results: _____

• Hobbies/Interests: _____

Please mark ALL areas of concern



GENERAL HEALTH HISTORY (Child)

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	❑	❑	Vision Problems
❑	❑	Ear Infections	❑	❑	Sleeping Problems
❑	❑	Colic	❑	❑	Growing Pains
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Temper Tantrums
❑	❑	Recurring Fevers	❑	❑	ADHD
❑	❑	Digestive Problems	❑	❑	Seizures
❑	❑	Bed Wetting	❑	❑	Scoliosis
❑	❑	Chronic Colds/Sinus	❑	❑	Ever Needed Stitches
❑	❑	Other _____			

1. List any medications being taken: _____
2. Number of courses of Antibiotics child has taken in the last 6 months: _____ Total during lifetime: _____
3. Name of Pediatrician and Other Doctors: : _____
4. Date of Last Visit _____/_____/_____ Reason: _____
5. Name of Obstetrician/Midwife: _____
6. Location of Birth: ❑Hospital ❑Birthing Center ❑Home
7. Complications During Pregnancy: ❑No ❑Yes – Explain: _____
8. Ultrasounds During Pregnancy: ❑No ❑Yes – How Many? _____
9. Medication During Pregnancy / Delivery: ❑No ❑Yes – List? _____
10. Cigarette / Alcohol Use during Pregnancy: ❑No ❑Yes
11. Has any Doctor / Professional advised you to "Take the child to a Chiropractor": ❑No ❑Yes – Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____
13. List any past falls bumps bruises: _____ Was any care received? _____
14. List any past sport, recreational, or home injuries_____
15. Please describe any past conditions and treatment received: _____

_____

16. 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? _____