SHEEHAN NATURAL HEALTH IMPROVEMENT CENTER

1301 E King St
Lancaster, PA 17602
Phone: 717-392-6606
Fax: 717-406-0959

ABOUT YOU

Today's Date: ____/____/____

Name: _____

What You Prefer To Be Called: _____ Male Femal

Birthdate: ____/____/____ Age: ____ SS#_____

Referred By: ☐ Current Patient: Name:_____
☐ Yellow Book ☐ Verizon Book ☐ Website ☐ Other _____

Employer & Address: _____

_____
CITY STATE ZIP

Occupation: _____ Work Phone # _____

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: _____

Home Address: _____

_____
CITY STATE ZIP

Cell Phone #:_____

Home Phone #: _____

E-mail: _____

May we send our informational newsletter and event announcements (infrequently) to your e-mail address?
Yes No
(we will never sell your e-mail address to anyone ever)

REASON FOR VISIT

Have you ever been treated by a Chiropractor? Yes No
Have you ever been treated by a Naturopathic Physician? Yes No
If so, when? _____
What did you see them for? _____

What is your **primary symptom or area of pain**?

_____
What is the pain level: (10 being the worst): 0 1 2 3 4 5 6 7 8 9 10

What is your **secondary symptom or area of pain**?

_____
What is the pain level: (10 being the worst): 0 1 2 3 4 5 6 7 8 9 10

When did condition begin? ____/____/____
How did the pain start? ☐Overexertion/strenuous position
☐Auto Accident/Work Injury ☐Fall/Trip/Slip
☐Other: _____

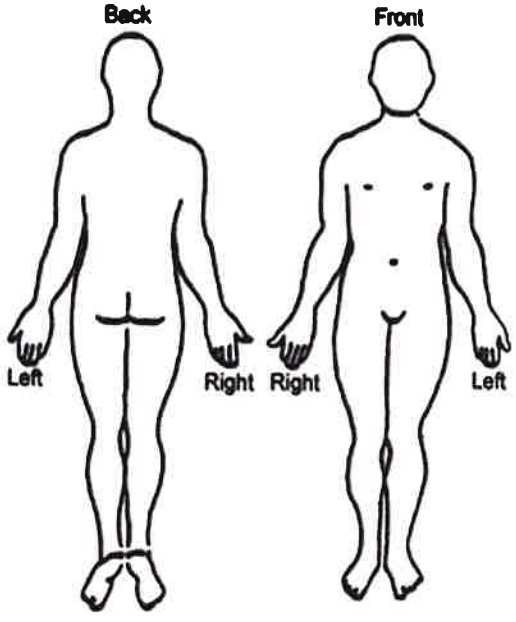
Is this condition getting worse? Yes No Constant Comes and goes
Is this condition interfering with your (*Please check the boxes that apply*):

Work (also check length of time)
☐Standing:
☐<10Min ☐10-30Min ☐30-60Min ☐>Hour
☐Sitting
☐<10Min ☐10-30Min ☐30-60Min ☐>Hour
☐Walking
☐<10Min ☐10-30Min ☐30-60Min ☐>Hour
☐Lifting
☐<10Min ☐10-30Min ☐30-60Min ☐>Hour
Addition details:

_____
_____

Sleep
☐Unable to sleep
☐Keep waking up
☐Non-restful sleep

Daily Routine



Mark an X on the picture above where you continue to have pain, numbness, or tingling.

PLEASE CONTINUE ON NEXT PAGE

REASON FOR VISIT Continued

What makes the pain worse?

- ☐ Coughing/Sneezing
- ☐ Bowl movement
- ☐Lifting
- ☐Bending
- ☐Push/Pull
- ☐Driving
- ☐Walking
- ☐Running
- ☐Standing
- ☐Sitting
- ☐Changing Position
- ☐Movement
- ☐Other: _____

What makes the pain better?

- ☐Rest/Inactivity
- ☐Sitting
- ☐Standing
- ☐Lying down
- ☐Hot/Cold Packs
- ☐Walking
- ☐Running
- ☐Changing body positions
- ☐Other: _____

Have you had this or similar conditions in the past? Yes
If so, please explain: _____

Have you been treated by a Medical Physician for this condition? Yes No
If so, where? _____

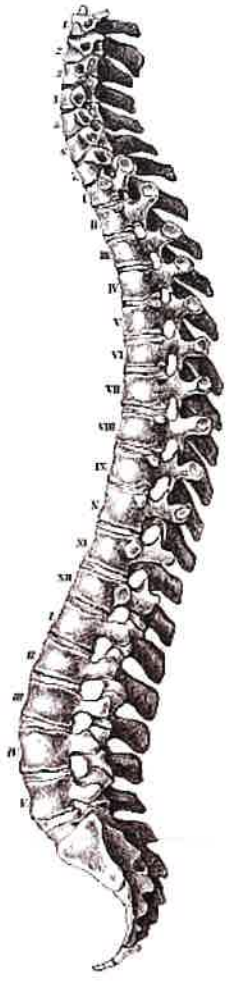
What other treatments have you attempted for this condition? _____

Additional Details:

_____

_____

_____



DIETARY AND LIFESTYLE

List the 5 foods (including drinks) you consume most often: BE HONEST!!

1) _____

2) _____

3) _____

4) _____

5) _____

How much water do you drink a day (in cups)? _____

What kind of exercise do you do? _____

_____

How often? _____

Do you want to lose weight? _____

How much? _____

How long do you want to live? (circle and check one).

60 ____ As long as I'm healthy and not a burden to others
65 ____ Whenever my number's up
70 ____ Forever
75 ____ It's already enough
80
85
90
100+

IN EVENT OF EMERGENCY

Who should we contact? _____
Relation: _____
Home Phone #: _____ Work Phone #: _____

Who is your Med. Doctor? _____
Phone #: _____

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxants Stimulants
Blood Thinners Tranquilizers Insulin Blood Pressure Meds
Cholesterol Meds Other(s) _____

Have you ever had any of the following diseases/medical conditions(s)?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / AIDS	Y N Shingles	Y N Arthritis
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Bulged Discs	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers/Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones/Joints	

Y N Psychiatric Disorder (Please Specify):_____
Y N Cancer (Please Specify):_____

If you circled yes to any of the above conditions, please explain:

_____
_

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates:
☐Neck Date: _____ ☐Back Date:_____ ☐Neck Date:_____ ☐Hip Left/Right Date:_____ ☐Knee Left/Right Date_____
☐Other:

_____

List any **past** serious accidents with dates: _____

_____

What is your stress level on a scale of 1-10? _____

What is the quality of your sleep? Good Fair Poor #Hours_____

How many bowel movements do you have per day? ____ Week? ____

IMPORTANT HEALTH INFO

Family Health History: Cancer Depression Diabetes Arthritis
Digestive/Gallbladder Problems
Heart Disease Other _____

Do you smoke? No Yes
How Much? _____ How Long? _____

Do you drink alcohol? No Yes
How much? _____ drinks/wk

What is your height? ____ft. ____in.

What is your current weight? _____lbs.

What is your blood type? A B AB O

For women: Are you taking Birth Control? Yes No

Are you Pregnant?
No Yes/How long? _____

Insurance Info.

Do you have health insurance? Y N

If yes, are you the policy holder? Y N

If you are not the policy holder, enter the policy holder's information below:
Name: _____
Date of Birth: _____
Relation: _____

*Please provide a copy of your ID and insurance card to the front desk.

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed to assess my condition and care for me in the office. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- **OFFICE POLICY:** Scheduled appointments must be rescheduled the day of canceled appointment.

Signature _____ Date ___/___/___

SHEEHAN

CHIROPRACTIC

DR. KEITH SHEEHAN, D.C.

1301 EAST KING STREET • LANCASTER, PA 17602 • (717) 392-6606

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name (Print): _____

Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and is located on this office's website, SheehanChiropractic.com.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian
(circle one)

Authorization to release Protected Health Information:
I authorize the following people to receive information regarding my care (please note any restrictions):

1._____

2._____