



# *Jensen Health & Energy Center, S.C.*

*500 Elm Grove Rd, Suite 325 Elm Grove, WI 53122*

*Phone: (262) 782-1616 Fax: (262) 782-7815*

*www.health-energy.com*

## **IMPORTANT INFORMATION TO THE PATIENT**

Jensen Health & Energy Center offers members of our community and the surrounding area the healing modalities of Chiropractic, Applied Kinesiology, Acupuncture, Nutrition and Herbs, Massage Therapy, CranioSacral, Roling and Body-Mind Coaching .

**APPOINTMENTS.** Quality health care necessitates that the practitioner thoroughly examine any patient being seen for the first time prior to rendering treatment. Since this requires an adequate amount of time, we schedule a longer appointment for the initial exam. Appointments are the patient's responsibility. By scheduling in advance, you can be certain you will get a time that is best for you. If an emergency exists, please advise the receptionist.

**RESCHEDULING.** It is important that any changes or rescheduling of appointments be made well in advance. Failure to do so deprives other patients of this time. You will be charged a \$35 fee for missed appointments or appointments not cancelled at least 24 hours in advance.

**CHIROPRACTIC RE-EXAMS.** If you have a new injury, new symptoms or a major change in your condition, please schedule a chiropractic re-exam in addition to treatment. This allows time for treatment since a re-exam is necessary in this type of situation. A re-exam is also necessary if you have not been in for more than two months. **WHEN YOU COME IN PLEASE FILL OUT AN "UPDATE FORM"**.

**PAYMENT.** You are responsible for payment of all services not covered by insurance at the time services are rendered. This includes Acupuncture, Massage, CranioSacral, Body-Mind Coaching, Roling and Wellness Care. You will be responsible to pay all copays for chiropractic services at the time of service. If there is any balance still owed due to deductible or services considered not medically necessary by your insurance we ask that you pay for those services as soon as you are billed. We send out monthly statements for your convenience. Please be sure to give the front desk staff your insurance card if your insurance information has changed since your last visit. Supplements and supplies can be returned if unopened within 30 days of purchase. If defective, please notify us immediately and we will exchange it for the same.

**PARTICIPATION.** It has been our experience that people get the best results when they **ACTIVELY PARTICIPATE** in taking responsibility for their own care. Once attaining your health goals, it is good to maintain your health with periodic visits. If you wish to discontinue care, speak with your doctor, as this will allow us to complete your file, and advise you on self care.

**PRIVACY.** Teamwork among our practitioners is part of the exceptional care we provide. If you choose to see more than one practitioner, we ask permission to discuss your case with that practitioner.

**ARBITRATION.** The patient and Jensen Health & Energy Center, S.C., agree that any dispute regarding the relationship between the patient and Jensen Health & Energy Center, S.C. and any of its practitioners or other employees shall be resolved by arbitration. Said Arbitration shall be in accordance with the rules and procedures of the American Arbitration Association.

If you have any concerns or questions about treatment or office procedure, please let us know so we can improve our services. If any questions remain, please inquire immediately.

I have read and understand the above information and policies.

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Signature

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Date

## PATIENT INTRODUCTION SHEET

Name \_\_\_\_\_  
(Last) (First) (Middle)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Ok to leave message? Home – Yes \_\_\_ No \_\_\_ Cell – Yes \_\_\_ No \_\_\_ Work – Yes \_\_\_ No \_\_\_

Would you like to be on our e-mail list? Yes \_\_\_ No \_\_\_

E-Mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
(month, date, year)

Social Security # \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Number of Children \_\_\_\_\_

Significant Other/Spouse's Name \_\_\_\_\_

Referred by: \_\_\_\_\_

Name of Person Responsible for Account (if not self) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Your Occupation or Profession \_\_\_\_\_

Employed by \_\_\_\_\_ Address \_\_\_\_\_

Have you ever been under the care of a Chiropractor/Acupuncturist/Homeopath/Rolfer/Nutritionist before? Yes \_\_\_ No \_\_\_

If yes, Who? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

All fees for services not covered by insurance are due at the time services are rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

***Jensen Health & Energy Center, S.C.***

*Jensen Health & Energy Center Patient History*

Name \_\_\_\_\_ Date \_\_\_\_\_

What is your main complaint? \_\_\_\_\_ Date problem began? \_\_\_\_\_

Have you seen someone for this problem? \_\_\_\_\_

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO

How often do you experience your symptoms?  Constantly (76-100% of the day)  Frequently (51-75% of the day)

Occasionally (26-50% of the day)  Intermittently (0-25% of the day)

Describe the nature of your symptoms:  Sharp  Dull  Numb  Burning  Shooting  Tingling  Radiating Pain

Tightness  Stabbing  Throbbing  Other: \_\_\_\_\_

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

1  2  3  4  5  6  7  8  9  10

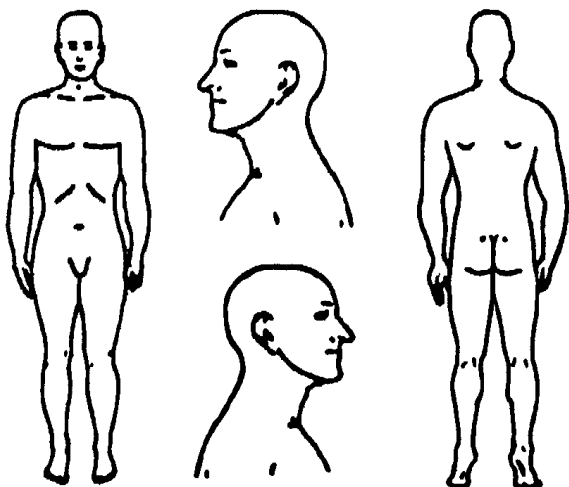
How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities)  1  2  3  4  5  6  7  8  9  10

What activities aggravate your condition (working, exercise, etc)? \_\_\_\_\_

What makes your pain better (ice, heat, massage, etc)? \_\_\_\_\_

**PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM**



Main reason for consulting the office:

- Become pain free
- Explanation of my condition
- Learn how to care for my condition
- Reduce symptoms
- Resume normal activity level

***Jensen Health & Energy Center, S.C.***

Name \_\_\_\_\_

List any **Allergies**:

- Animals  Aspirin  Bees  Chocolate  Dairy  Dust  Eggs  Latex  Molds  Penicillin  Ragweed/Pollen  
 Rubber  Seasonal Allergies  Shellfish  Soaps  Wheat  X-Ray Dye  Other: \_\_\_\_\_

List any **Surgeries**:

- Back  Brain  Elbow  Foot  Hip  Knee  Neck  Neurological  Shoulder  Wrist  Other: \_\_\_\_\_

List **ALL Past Medical History** conditions:

- Ankle Pain  Anxiety  Arm Pain  Arthritis  Asthma  Back Pain  Breast Lumps  Broken Bones  Cancer  
 Chest Pain  Constipation  Depression  Diabetes  Diarrhea  Dizziness  Elbow Pain  Epilepsy  
 Eye/Vision Problems  Fainting  Fatigue  Fear  Foot Pain  Genetic Spinal Condition  Hand Pain  Headaches  
 Hearing Problems  Heartburn  Hepatitis  High Blood Pressure  Hip Pain  HIV  Jaw Pain  Joint Stiffness  
 Knee Pain  Leg Pain  Menstrual Problems  Minor Heart Problem  Multiple Sclerosis  Neck Pain  
 Neurological Problems  Pacemaker  Parkinson's  Polio  Prostate Problems  Shoulder Pain  
 Significant Weight Change  Spinal Cord Injury  Sprain/Strain  Stroke/Heart Attack

Other: \_\_\_\_\_

Have you had any auto or other accidents?  No  Yes If yes when? \_\_\_\_\_

Describe \_\_\_\_\_

List Type of **Medications** you are taking:

- Anxiety  Muscle Relaxors  Pain Killers  Insulin  Birth control  Cardiovascular  Allergy  Seizure  
 Other: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_ By whom? \_\_\_\_\_

Do you smoke?  No  Yes

Do you drink alcohol?  No  Yes - how many per day? \_\_\_\_\_

Do you drink caffeine?  No  Yes - how many per day? \_\_\_\_\_

Do you exercise?  No  Yes (what forms and how often): \_\_\_\_\_

Do you sleep well?  No  Yes \_\_\_\_\_

How is your general energy level? \_\_\_\_\_

Are you or could you be pregnant?  No  Yes

Name \_\_\_\_\_

List your **Family History**:

- Arthritis  Asthma  Back Pain  Cancer  Depression  Diabetes  Epilepsy  Genetic Spinal Condition
- High Blood Pressure  Heart Problems  Multiple Sclerosis  Neurological Problems  Parkinson's  Polio
- Prostate Problems  Stroke/Heart Attack

Other: \_\_\_\_\_

What is your SECOND complaint? \_\_\_\_\_ Date problem began? \_\_\_\_\_

How did this problem begin (falling, lifting, etc.)? \_\_\_\_\_

How is your condition changing?  GETTING BETTER  GETTING WORSE  NOT CHANGING

Have you had this condition in the past? YES - NO

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