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 and Rolfing.

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 $50.00 fee for missed appointments or appointments not cancelled at least 24 hours in advance.

PAYMENT. You are responsible for payment of all services not covered by insurance at the time services are rendered. This includes Acupuncture, Massage, CranioSacral, Rolfing 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.

_____ _____

Signature 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_____Gender_____
(month, date, year)

Single_____Married_____Widowed_____ Divorced_____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/ /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.

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: _____

What is your pain level right now- on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What is your typical or average pain?

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

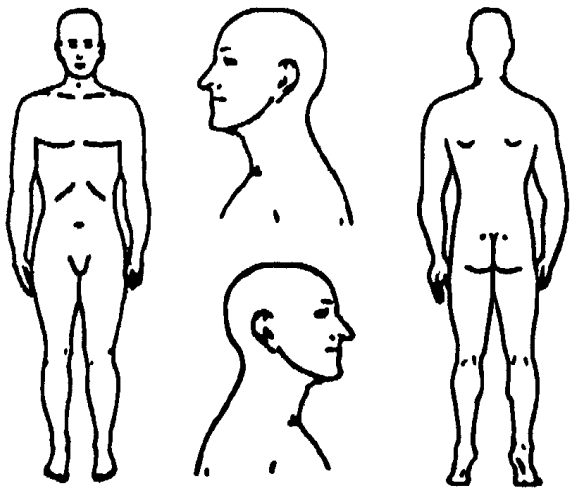
How do your symptoms affect your ability to perform daily activities such as working or driving?

(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

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Name _____ Date _____

Family Medical History

☐ Alcoholism
☐ Asthma
☐ Hardening of the Arteries
☐ Cancer (who & what type) _____ _____ _____
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Seizures
☐ Stroke

Your Medical History

(Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are significant part of your medical history.)

☐ AIDs/HIV
☐ Alcoholism
☐ Allergies (list) _____
☐ Birth Trauma (your own birth)
☐ Cancer (what type) _____
☐ Chicken Pox / Shingles
☐ Diabetes
☐ Emphysema / COPD
☐ Epilepsy
☐ Gout
☐ Hardening of the Arteries
☐ Heart Disease / Heart Attack
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Lyme Disease
☐ Multiple Sclerosis
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Stroke / TIAs
☐ Thyroid Disorders
☐ Tuberculosis
☐ Tumors
☐ Surgery (list) _____
☐ Major Trauma (car accident, fall, etc. – list) _____
☐ Ulcers
☐ Whooping Cough
☐ Other (specify) _____

Have you been out of the country? ☐ Yes ☐ No

Your Diet

Appetite ☐ Low ☐ High

☐ Coffee ☐ Soft Drinks
☐ Artificial Sweetener
☐ Sugar ☐ Salty Food
☐ Thirst for Water # of glasses per day _____

Average Daily Menu

Morning	Snack	Noon	Snack	Evening	Snack

Medications taken in last 2 months:

Vitamins/supplements taken in last 2 months:

Your Lifestyle

☐ Alcohol
☐ Tobacco
☐ Stress
☐ Occupational Hazards

Regular Exercise

Type _____ Frequency _____

Type _____ Frequency _____

General Symptoms

☐ Poor Appetite
☐ Heavy Appetite
☐ Strongly Like Cold Drinks
☐ Strongly Like Hot Drinks
☐ Recent WeightLoss/Gain
☐ Poor Sleep
☐ Heavy Sleep
☐ Dream-disturbed Sleep
☐ Fatigue
☐ Lack of Strength
☐ Bodily Heaviness
☐ Cold Hands or Feet
☐ Poor Circulation
☐ Fever
☐ Chills
☐ Night Sweats
☐ Sweat Easily
☐ Muscle Cramps
☐ Vertigo or Dizziness
☐ Bleed or Bruise Easily
☐ Peculiar Taste (describe) _____

Cardiovascular

☐ High Blood Pressure
☐ Blood Clot
☐ Low Blood Pressure
☐ Fainting
☐ Chest Pain
☐ Difficulty Breathing
☐ Rapid Heart Beat
☐ Heart Palpitations
☐ Phlebitis
☐ Irregular Heart Beat

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Regurgitation
- ☐ Gas
- ☐ Hiccup
- ☐ Bad Breath
- ☐ Heartburn
- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative Use
- ☐ Black Stools
- ☐ Bloody Stools
- ☐ Mucous in Stools
- ☐ Intestinal Pain or Cramping
- ☐ Itching Anus
- ☐ Burning Anus
- ☐ Rectal Pain
- ☐ Hemorrhoid
- ☐ Anal Fissures
- ☐ Bowel Movements

Frequency _____

Texture/Form _____

Color _____

Other _____

Genito-urinary

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Urgent Urination
- ☐ Unable to Hold Urine
- ☐ Wake to Urinate
- ☐ Bedwetting
- ☐ Incomplete Urination
- ☐ Blood in Urine
- ☐ Sexually Transmitted Diseases
- ☐ Kidney Stone
- ☐ Prostate Problems
- ☐ Increased Libido
- ☐ Decreased Libido
- ☐ Erectile Dysfunction
- ☐ Premature Ejaculation
- ☐ Nocturnal Ejaculation

Gynecology

Age Period Began _____

Length of Cycle (# of days) _____

Duration of Flow (# of days) ____

Date Last Period Began _____

Age at Menopause _____

- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ PMS
- ☐ Clots
- ☐ Hot Flashes
- ☐ Vaginal Discharge (color) _____
- ☐ Vaginal Sores
- ☐ Vaginal Odor
- ☐ Breast Lumps

Are you or might you be pregnant ☐ Yes ☐ No

# of Pregnancies _____

# of Live Births _____

# of Premature Births _____

Date of last PAP test _____

Date of last thermography or mammogram _____

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Spots in Eyes
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Night Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth Problems
- ☐ Grinding Teeth
- ☐ TMJ
- ☐ Facial Pain
- ☐ Gum Problems
- ☐ Sores on Lips or Tongue
- ☐ Dry Mouth
- ☐ Excessive Saliva
- ☐ Sinus Problems
- ☐ Nasal Discharge Color _____
- ☐ Earaches
- ☐ Recurrent Sore Throat
- ☐ Swollen Glands
- ☐ Lumps in Throat
- ☐ Enlarged Thyroid
- ☐ Nose Bleeds
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Headaches
- ☐ Migraines
- ☐ Other Head or Neck Problem _____

Musculoskeletal

- ☐ Neck Pain
- ☐ Muscle Pain
- ☐ Sprain/Strain
- ☐ Spine Injury
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Joint Injury
- ☐ Rib Pain
- ☐ Limited Range of Motion
- ☐ Limited Use
- ☐ Upper Extremity Pain (shoulder, arm, elbow, wrist, hand pain)
- ☐ Lower Extremity Pain (hip, knee, ankle, feet pain)
- ☐ Other (describe) _____

Neuropsychological

- ☐ Seizures
- ☐ Numbness/Tingling
- ☐ Tics
- ☐ Concussions
- ☐ Poor Memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily Stressed
- ☐ Abuse Survivor
- ☐ Parkinson's Disease
- ☐ Fear
- ☐ Considered/Attempted Suicide
- ☐ Other (specify) _____

Respiratory

- ☐ Difficulty Breathing when Lying Down
- ☐ Shortness of Breath
- ☐ Tight Chest
- ☐ Wheezing
- ☐ Cough

Color of Phlegm _____

Wet or Dry? _____

Thick or Thin? _____

- ☐ Coughing Blood
- ☐ Other _____

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulceration
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair Loss
- ☐ Change in Hair/Skin Texture
- ☐ Fungal Infection
- ☐ Rosacea
- ☐ Other Hair or Skin Problems

Other

INSURANCE INFORMATION SHEET

(Please print legibly) Date Insurance Is In Effect _____

Name of **Primary** Insurance Company_____

Address_____

City _____State _____Zip_____

I.D. # _____Group or Policy # _____

Name of Policy Holder _____
(Last) (First) (Middle)
Address _____

City _____State _____Zip _____

Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

Name of **Secondary** Insurance Company _____

Address_____

City _____State _____Zip _____+_

I.D. # _____Group or Policy # _____

Name of Policy Holder
_____
(Last) (First) (Middle)
Address _____

City _____State _____Zip_____

Relation to Policy Holder: Self _____ Spouse _____ Child _____ Other _____

I authorize Jensen Health & Energy Center, S.C. to submit insurance claim forms (paper or electronic), insurance reports, and any other information, requested by the carrier, to the above insurance companies or their representatives.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____

Parent Signature (if under 18) _____

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