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.

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Signature____Date___________________

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

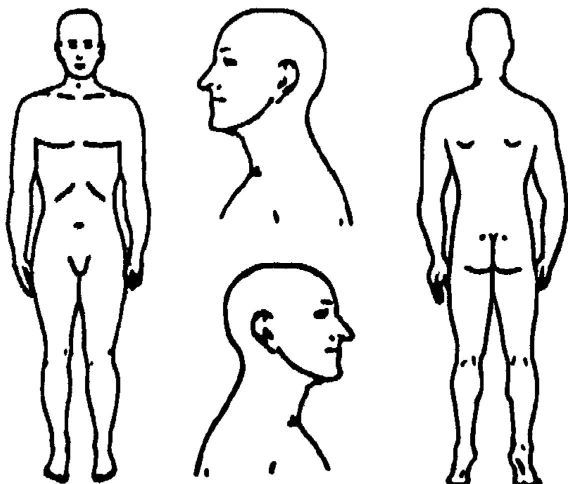
How do your symptoms affect your ability to perform daily activities such as working or driving?

(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



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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

Main reason for consulting the office:

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) ______________________
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ 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

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______________________________ ________________________

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)

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____
____
____

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 Probler

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____
____

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) ________________________

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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