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, Rolfing 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, 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 key to our high level of quality of care, we ask permission to discuss your case with other staff practitioners.

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

Jensen Health & Energy Center

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 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

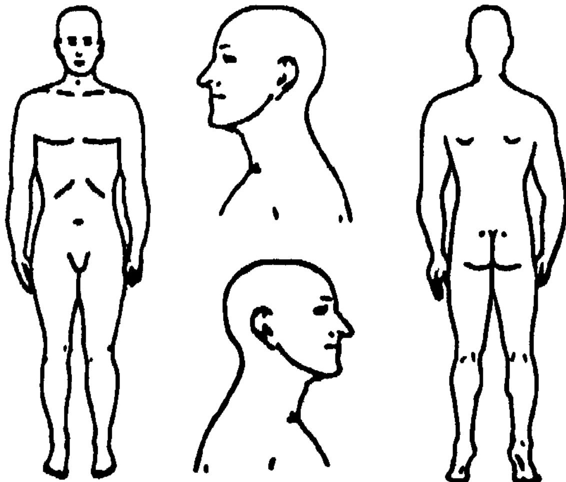
How do your symptoms affect your ability to perform daily activities such as working or driving?

(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 BELOW



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

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

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)? ____________________________________