



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

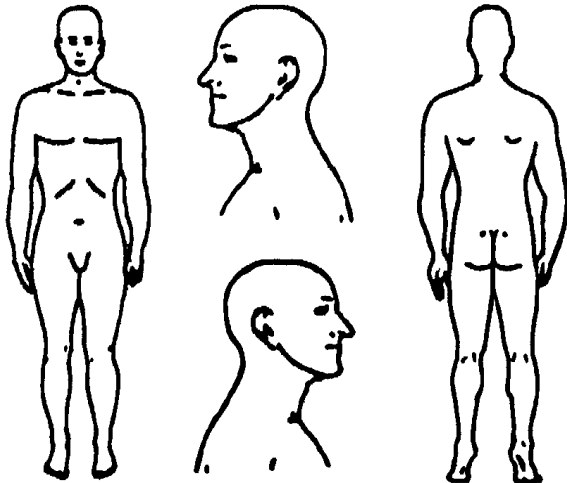
How do your symptoms affect your ability to perform daily activities such as working or driving?

(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?

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

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

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) _____