MountainValley CHIROPRACTIC

2026

CHIROPRACTIC CARE CONSENT

Thank you for choosing Mountain Valley Chiropractic. We look forward to providing quality healthcare to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all the following questions. All information will be held in the strictest of confidence.

Name________________________________ Age____ DOB__________ M F Marital Status______ Phone__________________
Address____ City/State_______________________ Zip_____________
Email ____________________________ Occupation______________________ **Enrolled in Medicare/Medicare Advantage? Y N**
Emergency Contact Name_____________________________________ Relation__________________ Phone_________________
Who referred you to us? ____ May we thank him/her? Y N

*I voluntarily consent to be treated with chiropractic care by Joseph Heinecke, DC, of Mountain Valley Chiropractic.
*Mountain Valley Chiropractic does not accept assignments for Medicare or insurance. This means that Mountain Valley Chiropractic does not see any Medicare-enrolled persons. If you become Medicare enrolled while under the course of care by Mountain Valley Chiropractic, you will be referred to an appropriate Medicare provider. If you have insurance that contributes to your care, Mountain Valley Chiropractic will provide you with the appropriate documentation in the form of a "superbill" to help you with direct reimbursement from your insurance company. Mountain Valley Chiropractic cannot guarantee that your insurance company will reimburse you for services provided and assumes no role in recovering a reimbursement from your insurance company.
*I understand that chiropractic care involves hands-on touching of my body and can include sensitive areas including hips, sacrum, coccyx (tail bone), pubic bone, collar bones and ribs, lymph nodes in the armpits as well as palpation of muscles of both the upper and lower body. Some contact may need to be performed skin-to-skin, but most will be performed over my clothing. If at any time throughout the course of care I feel uncomfortable or do not want contact made with a specific body part, I will let Dr. Heinecke know so that other arrangements for care may be made. **Please initial for consent _______**
*I understand that some diagnostic or examination procedures may be performed if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Exams will be performed at the onset of care, annually, or in the instance of an auto accident or serious injury.
*I understand that chiropractic care involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. Hands or an instrument is used to reposition anatomical structures. Potential benefits include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and well-being.
*I understand that no guarantees are given to me concerning the results and effects, and that I am free to stop or refuse treatment at any time. I also understand that there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. The best scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis. Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not.
*I understand that Dr. Heinecke does not diagnose or treat any condition other than Vertebral Subluxation. However, while under the course of care, if he finds or suspects a different or more serious condition requiring treatment, he will inform you as well as recommend that you seek the services of a healthcare provider that specializes in that area of treatment.
*Your privacy is important to us. Mountain Valley Chiropractic follows the Health Insurance Portability and Accountability Act (HIPAA). You have the right to review our HIPAA guidelines upon request. At times you may wish to contact Mountain Valley Chiropractic via email, or vice versa, for communication which may contain protected health information. **Initial _______**
*I understand payment is due at the time of service and I agree to address any financial concerns with Mountain Valley Chiropractic prior to treatment. I understand that Mountain Valley Chiropractic accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. **Initial _______**

*The above-named patient is a minor. As his/her parent/guardian, I give Dr. Heinecke permission to treat him/her without me being present at said treatment.
Please sign for consent to treat your minor child ____ Date__________________

I have carefully read and I understand the above information. I am fully aware of what I am signing.

____ ____________________________
Signature (Patient / Parent / Guardian) **Date**

Adult Health History

(Ages 13+)

Name: ______________________________ DOB: ____________ Date: ____________

Spouse's Name: ______________________ Children's Names: ______________________

Occupation: ______________________ Employer: ______________________

Enrolled in Medicare/Medicare Advantage? Yes No E-Mail: ______________________

Is today's visit due to: Illness Accident Injury Other ______________________

Job related? Yes No Automobile related? Yes No

Chief Complaint: ____

Circle the type of pain: Sharp Dull Burning Achy Throbbing Numb

How and when did it start? ____

What makes it better? ______________________ What makes it worse? ______________________

Have you been treated for this condition before? Yes No If yes, by whom? ______________

Are you currently under a healthcare provider's care for any other problems? Yes No

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Previous Chiropractic Care: Last visit? Reason? Duration of care? ______________________

____

Current Medications/Supplements: ____

____

Hospital/ER Visits/Surgeries? ____

____

Other Injuries/Accidents: ____

Rate the Following:	Poor		Average		Exceptional
General Health	O	O	O	O	O
Overall Diet	O	O	O	O	O
Exercise Routine	O	O	O	O	O
Overall Stress	O	O	O	O	O
Sleep	O	O	O	O	O

What **Physical Stresses/Injuries** have you experienced recently? ______________________

____

E**motional Stresses** (Grief, Loss, Fear, Family, Money, etc.)? ______________________

____

Chemical Stresses - Do you smoke? Yes No Never Packs/day? ______ How long? ________

Do you use alcohol? Yes No Never Drinks/day? ______ per week? ________

Do you use recreational drugs? Yes No Never How often? ______________

Water Intake – How much water do you drink per day? ______ ounces Type of water? ______________

Have you experienced any of the following? (circle one):

Illnesses/Frequent Colds/Ear Infections?	Y	N	Don't Know
Medication/Antibiotics/Inhaler?	Y	N	Don't Know
Falls/Injuries?	Y	N	Don't Know
Hospitalizations/Surgeries?	Y	N	Don't Know
Braces?	Y	N	Don't Know
Physical/Emotional/Sexual Trauma?	Y	N	Don't Know
Car Accidents?	Y	N	Don't Know
Difficult Birth (breech, forceps, vacuum, c-section)?	Y	N	Don't Know
Vaccine Reactions (fever, seizures, personality changes)?	Y	N	Don't Know

Have you or anyone in your immediate family experienced the following now OR in the past?

Check **O** *for You. Check □ for Immediate Family. Fill in type of condition on the line next to illness.*

O □ Alcoholism/Substance Abuse
O □ Allergies ____________________
O □ AIDS/HIV
O □ Anemia
O □ Asthma and/or Shortness of Breath
O □ Attention Deficit Disorder
O □ Back Pain, Spine or Disc Problems
O □ Bedwetting
O □ Blood Pressure Problems
O □ Brain Fog
O □ Bursitis
O □ Cancer ____________________
O □ Constipation or Diarrhea
O □ Depression, Fatigue or Lack of Energy
O □ Diabetes Type ____ or Blood Sugar Issues
O □ Digestive Disorders __________________
O □ Dizziness or Loss of Consciousness
O □ Emphysema
O □ Epilepsy or Seizures
O □ Fibromyalgia
O □ Gallbladder Disease
O □ GERD or Heartburn
O □ Gout
O □ Hand or Wrist Pain or Carpal Tunnel
O □ Heavy Metals
O □ Hip, Knee or Foot Pain, Numbness or Tingling
O □ Hormone Balance and Related Concerns
O □ Heart Disease and/or High Cholesterol
O □ Hepatitis _____
O □ Herpes ____________________
O □ Inflammation or Arthritis
O □ Insomnia or Sleeping Problems
O □ Kidney Disease
O □ Learning Challenges ____________________
O □ Lymphatic Blockage
O □ Menopause
O □ Mental Illness ____________________
O □ Migraine, Stress or Tension Headaches
O □ Multiple Sclerosis
O □ Neck Pain and Stiffness
O □ Neuropathy/Nerve Problems
O □ PMS
O □ Poor Circulation
O □ Pregnancy and/or Fertility Issues
O □ Prostate Problems
O □ Sciatica
O □ Shoulder or Arm Pain, Numbness or Tingling
O □ Spinal Curvature
O □ Stress, Anxiety or Nervousness
O □ Stroke or TIA
O □ Thyroid Disease
O □ Tinnitus (ringing in ears)
O □ Tuberculosis
O □ Ulcers
O □ Urinary Problems
O □ Weakened Immune System
O □ Weight Gain/Loss
O □ Yeast/Fungus/Mold/Parasites

Patient Name: ___________________________ Signature: __________________________ Date: ___/___/___

Patient Quality of Life Survey

Name: ______________________________ **Date:** ____________________

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): ______________________________

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ Haven’t Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

____

____

____

____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. ______________________________
2. ______________________________
3. ______________________________

08 **What are you most concerned with regarding your problem?**

____

____

____

____

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

____

____

____

____

10 **What would be different/better without this problem? Please be specific.**

____

____

11 **What do you desire most to get from working with us?**

____

____

12 **What would that mean to you?**

____

____

MountainValley
CHIROPRACTIC

WELLNESS EVALUATION

Name: ______________________________ Date: ________________

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:
- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:
- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:
- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:
- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:
- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:
- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:
- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:
- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:
- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL __________

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