Anderson Chiropractic

Confidential Patient Information

Please Print Clearly

Name _____ Street Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Date of Birth _____ Age _____ Sex ☐ M ☐ F Social Security # _____

E-mail _____ Driver's License # _____ Occupation _____

Employer _____ Street Address _____

City, State, Zip _____ Work Phone ( ) _____

☐ Single ☐ Married Spouse's Name _____

In case of emergency, please contact _____ phone ( ) _____

Relationship to patient: _____

How were you referred to this office? _____ **May we thank him/her?** __

Have you ever had Chiropractic Care before? ☐ No ☐ Yes **If yes, when?** _____

****

Is this injury work related? ☐ No ☐ Yes, If yes, have you reported it to your employer? ☐ No ☐ Yes

Please list your chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

1. **All visit charges are payable when the services are rendered.** If you would like us to submit statements to your insurance company, please provide your insurance card to be copied and write the name of the company here _____.

2. The fee paid for X-rays is for analysis only. The film itself is part of our medical records and is the property of this office.

Method of payment you plan to use for today's charges ☐ Cash/Check ☐ MC/Visa ☐ Amex ☐ Discover

Patient's Signature _____ Date _____

CONTINUED ⟶

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Confidential Patient Health History

Please indicate if you have in the past or are currently experiencing health problems related to your cervical spine? (neck) Check all that apply.

Previous	Current		Previous	Current		Previous	Current	
☐	☐	Neck Pain	☐	☐	Headaches	☐	☐	Eye Pain
☐	☐	Pain into Shoulders	☐	☐	Ear Infections	☐	☐	TMJ
☐	☐	Buzzing or Ringing in Ears	☐	☐	Change in Vision	☐	☐	Deafness
☐	☐	Numbness in Hands	☐	☐	Sinus Problems	☐	☐	Dizziness
☐	☐	Pain into Arms or Hands						

Problems relating to your thoracic spine? (mid back) Check all that apply.

Previous	Current		Previous	Current		Previous	Current	
☐	☐	Pain between Shoulders	☐	☐	Mid Back Pain	☐	☐	Bursitis
☐	☐	Pain over Heart	☐	☐	Nervousness	☐	☐	Fatigue
☐	☐	Indigestion or Heartburn	☐	☐	Liver Problems	☐	☐	Arthritis
☐	☐	Gallbladder Problems	☐	☐	Chronic Cough	☐	☐	Asthma
☐	☐	Difficulty Breathing	☐	☐	Slow Heart Beat	☐	☐	Ulcers
☐	☐	High Blood Pressure	☐	☐	Fast Heart Beat	☐	☐	Chest Pain
☐	☐	Low Blood Pressure						

Problems relating to your lumbar spine? (low back) Check all that apply.

Previous	Current		Previous	Current		Previous	Current	
☐	☐	Swollen or Weak Ankles	☐	☐	Low Back Pain	☐	☐	Bed Wetting
☐	☐	Numbness in Legs or Feet	☐	☐	Menstrual Cramps	☐	☐	Diarrhea
☐	☐	Difficulty with Pregnancy	☐	☐	Poor Leg Circulation	☐	☐	Foot Trouble
☐	☐	Irregular Menstrual Periods	☐	☐	Pain in Legs or Feet			
☐	☐	Frequent or Painful Urination	☐	☐	Sexual Problems			

Have you ever, or are you currently experiencing any of the following conditions: Check all that apply.

Previous	Current		Previous	Curent		Previous	Current	
☐	☐	Polio	☐	☐	TB	☐	☐	Coughing blood
☐	☐	Stroke	☐	☐	Heart Attack	☐	☐	Change in Moles
☐	☐	Vomiting Blood	☐	☐	Blood in Urine	☐	☐	Inhale Fumes
☐	☐	Hepatitis	☐	☐	HIV/AIDS			

Has any member of your family had: Check all that apply:

Previous	Current		Previous	Current	
☐	☐	High Blood Pressure	☐	☐	Cancer
☐	☐	Diabetes	☐	☐	Heart Attack
☐	☐	Thyroid Condition	☐	☐	Stroke
☐	☐	Arthritis or Joint Disease			

For Women Only: Check all that apply

Currently Pregnant ☐ Yes ☐ No Lumps in Breast ☐ Previous ☐ Current PMS ☐ Previous ☐ Current

Total # of Pregnancies _____ Please list any other female problems:_____

Date of last menstrual period:_____ Birth Control Used_____ ☐ None