Welcome to Anderson Chiropractic & Wellness Center

About You

Date:

Patient Name _____ (Last) _____ (First) _____ (M.I.)

Male ☐ Female ☐ I would prefer to be called: _____

Birthdate _____ Age _____ SS# ___ - ___ - _____

Street Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile _____

Email Address _____

Occupation _____

Employer _____ How Long? _____

Employer Address _____

City _____ State _____ Zip Code _____

Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name _____ Number of children? _____

Who may we thank for your referral? _____ PCP _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No Name

Your Health History

Date of last:

Physical Exam _____ X-Ray _____

Spinal Exam _____ MRI, CT or Bone Scan _____

Are you taking any of the following medications? ☐ Nerve pills ☐Pain Killers (including aspirin) ☐Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other (s) _____

Place a mark on "Yes" or "No" to indicate if you've had any of the following:

AIDS/HIV	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Other Headaches	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Digestive Disorder	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Numbness	☐ Yes ☐ No	Other	
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	_____	
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	_____	
Fractures	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No		

EXERCISE
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS
- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please describe any injuries or surgeries you have had:

_____

_____

Your Concerns

What is your major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Other doctor(s) that treated you for this condition:

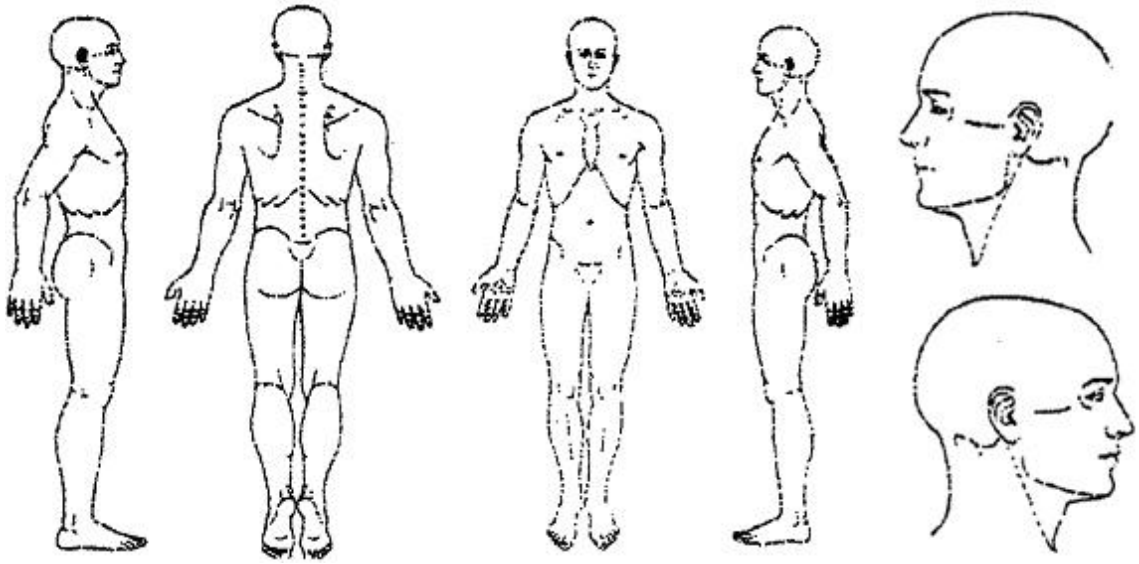
Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of pain:

☐ **S**harp ☐ **D**ull ☐ **Th**robbing ☐ **A**ching ☐ **Sh**ooting

☐ **B**urning ☐ **N**umbness ☐ **T**ingling ☐ **St**iffness ☐ **O**ther

Place appropriate highlighted letters to mark the areas of discomfort



How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

Does it interfere with Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Who else have you seen for this problem? _____

Other comments or concerns regarding your condition:

_____

Name of party responsible for payment Phone

Do you have health insurance? ◯ ◯ Name of company

*If an auto accident, please provide:

Insurance Company Name Contact Person

Phone: Claim #

Patient Signature: _____ _____

If patient is under 18:

Guardian Signature _____ Date _____