



**CONFIDENTIAL PERSONAL HISTORY**  
(Please Print)

File No. \_\_\_\_\_  
Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Email address: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Martial Status: M S W D # of Children: \_\_\_\_\_  
Name of spouse: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Nearest relative NOT living with you: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Nearest friend NOT living with you: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Occupation \_\_\_\_\_ Employed by: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Previous Chiropractic Care (Yes) (No) If yes, with whom? \_\_\_\_\_  
Name of Family Physician \_\_\_\_\_  
Do you have health insurance? \_\_\_\_\_ What Company? \_\_\_\_\_  
Primary Subscriber (circle - Spouse / Parent / Other) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_  
Present complaint (please explain) \_\_\_\_\_

Cause \_\_\_\_\_ Date of Onset \_\_\_\_\_ Duration \_\_\_\_\_  
Treatment thus far for this complaint \_\_\_\_\_

History: Injuries, (auto, etc.) EXPLAIN \_\_\_\_\_

**DO NOT WRITE IN THIS SPACE**

Put An X In Front Of The Following Illnesses Which You Have Had:

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Measles        | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Gonorrhea         | <input type="checkbox"/> "Leaking" Heart (Murmurs) |
| <input type="checkbox"/> Mumps          | <input type="checkbox"/> Pleurisy     | <input type="checkbox"/> Syphilis          | <input type="checkbox"/> Rheumatic Fever (Chorea)  |
| <input type="checkbox"/> Chickenpox     | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gall Stones       | <input type="checkbox"/> Hepatitis or Jaundice     |
| <input type="checkbox"/> Shingles       | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Kidney Stones     | <input type="checkbox"/> Hives or Eczema           |
| <input type="checkbox"/> Smallpox       | <input type="checkbox"/> Goiter       | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Any Bone or Joint Disease |
| <input type="checkbox"/> Diphtheria     | <input type="checkbox"/> Migraine     | <input type="checkbox"/> Meningitis        | Family History _____                               |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Anemia       | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Low Blood Pressure        |
| <input type="checkbox"/> Polio          | <input type="checkbox"/> Fractures    | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> Scarlet Fever  | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Vaccination Status        |
| <input type="checkbox"/> Hay Fever      | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Influenza - Date _____    |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Other             | <input type="checkbox"/> Shingles - Date _____     |
| <input type="checkbox"/> Diabetes       |                                       |  | <input type="checkbox"/> Covid Mfg _____           |
- Dates \_\_\_\_/\_\_\_\_/\_\_\_\_

Family History – Put and X in Front of Those That Apply:

	Living	Dead	Cancer	T.B.	Diabetes	Allergy	Heart	Arthritis	Spine Issues	Other
Father	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Put The Date In Front Of Those Operations Which You Have Had:

_____ Cholecystectomy (Gall Bladder Operation)	_____ Tonsillectomy
_____ Herniorraphy (Hernia Operation)	_____ Adenoidectomy
_____ Hemorrhoidectomy (Rectal Operation)	_____ Appendectomy
_____ Hysterectomy (Uterine Operation)	_____ Vaginal Repair
_____ Prostatectomy (Prostate Operation)	_____ Other Surgery

PUT AN X INFRONT OF THE FOLLOWING WHICH PRESENTLY APPLY PATIENT NAME \_\_\_\_\_

**EYES**

- Double Vision
- Glasses
- Burning
- Eye Strain
- Sensitive to Light

**EARS**

- Deafness
- Discharge
- Ringing
- Excess Wax

**SKIN**

- Rashes
- Eruptions
- Discolorations

**WEIGHT**

- Gain
- Loss
- Hold the Same

**NOSE**

- Sinusitis
- Bleeding
- Post Nasal Drip
- Obstruction

**THROAT**

- Soreness
- Hoarseness
- Difficulty Swallowing

**HEAD**

- Headaches
- Trauma
- Dizziness
- Fainting

**CHEST**

- Pain
- Heart Pounding
- Difficult Breathing
- Cough up Blood or Sputum

**MUSCULAR**

- Numbness
- Joint Pain
- Varicosities
- Swelling of Hands or Feet

**URINARY (URINATION)**

- Abnormally Frequent
- Burning
- Pain
- Discolored with Pus or Blood

**FEMALE (ONLY)**

- Periods Irregular
- Period Regular
- Duration of Periods \_\_\_\_\_
- Number of Pregnancies \_\_\_\_\_
- Complications During any Pregnancy \_\_\_\_\_
- Menopause

**HAND PREFERENCE**

- Right  Left
- Ambidextrous

**STOMACH OR INTESTINES**

- Poor Appetite
- Nausea
- Vomiting
- Belching
- Diarrhea
- Constipation

**HABITS**

- Coffee/ Tea \_\_\_ cups/day
- Soda/ Pop \_\_\_ cups/day
- Milk
- Water
- Fruit Juices
- Alcohol
- Cigarettes \_\_\_ packs/day
- Former smoker  
Date quit \_\_\_\_\_
- Vape use  
Freq \_\_\_\_\_ / \_\_\_\_\_
- Drugs (Pot, etc)
- Diets
- Other

PUT AN X IF YOU TAKE ANY OF THE FOLLOWING DRUGS: (add the name of any medication on the line provided)

	NEVER	OCCASIONALLY	FREQUENTLY	DAILY
LAXATIVES _____	_____	_____	_____	_____
DIURETICS (WATER PILLS) _____	_____	_____	_____	_____
APPETITE SUPPRESSANTS _____	_____	_____	_____	_____
VITAMINS _____	_____	_____	_____	_____
ANITBIOTICS _____	_____	_____	_____	_____
ASPIRIN (OR RELATED COMPOUNDS) _____	_____	_____	_____	_____
SLEEPING PILLS _____	_____	_____	_____	_____
SEDATIVES (TRANQUILIZERS) _____	_____	_____	_____	_____
HYPOTENSIVE AGENTS (BLOOD PRESSURE) _____	_____	_____	_____	_____
DIGITALIS _____	_____	_____	_____	_____
NITROGLYCERINE _____	_____	_____	_____	_____
CORTISONE, ACTH OR OTHER STEROIDS _____	_____	_____	_____	_____
ORINASE, DIABENESE _____	_____	_____	_____	_____
INSULIN _____	_____	_____	_____	_____
DIABETIC MEDICATIONS _____	_____	_____	_____	_____
THYROID _____	_____	_____	_____	_____
WEIGHT LOSS MEDICATION _____	_____	_____	_____	_____
GI (BOWEL) MEDICATION _____	_____	_____	_____	_____
OTHER HORMONES (BIRTH CONTROL, ETC) _____	_____	_____	_____	_____
OTHER DRUGS (KIND) _____	_____	_____	_____	_____

**X-RAY SURVEY:**

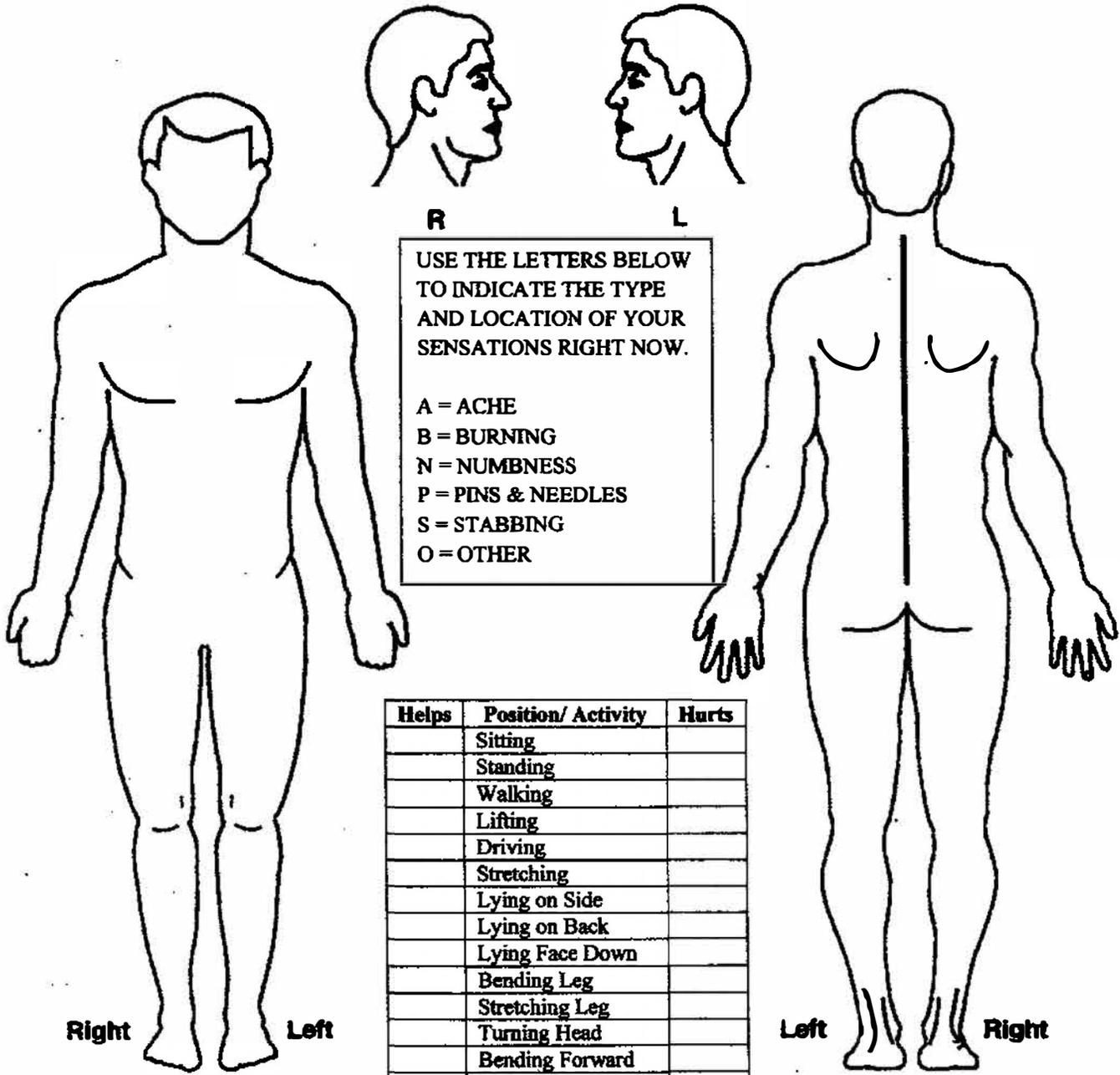
Have you been X-rayed before \_\_\_\_\_ When: \_\_\_\_\_ How many times \_\_\_\_\_  
 Where \_\_\_\_\_ What region of the body?: \_\_\_\_\_  
 Did you ever have x-ray treatments?: \_\_\_\_\_ When?: \_\_\_\_\_ How long?: \_\_\_\_\_  
 Have you had Chemotherapy treatments?: \_\_\_\_\_ When?: \_\_\_\_\_ How long?: \_\_\_\_\_  
 FEMALE ONLY: Are you pregnant at the present time?: \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

**ANDERSON CHIROPRACTIC**  
**CHIROPRACTIC ORTHOPEDIC, PHYSICAL & NEUROLOGICAL EXAMINATION**

Patient Name \_\_\_\_\_ Pt #: \_\_\_\_\_ Date of Consultation: \_\_\_\_\_

**REQUIRED FOR YOUR CASE HISTORY FILE**  
 (to be completed by the patient)  
**INDICATE YOUR AREAS OF PAIN**



Helps	Position/ Activity	Hurts
	Sitting	
	Standing	
	Walking	
	Lifting	
	Driving	
	Stretching	
	Lying on Side	
	Lying on Back	
	Lying Face Down	
	Bending Leg	
	Stretching Leg	
	Turning Head	
	Bending Forward	
	Bending Backward	
	Pushing	
	Pulling	
	Carrying	
	Other: Describe	



**ANDERSON  
CHIROPRACTIC  
and Massage**

Patient # \_\_\_\_\_

**New Patient Nutritional Information Intake**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender: Male Female Other

Phone #: (\_\_\_\_) \_\_\_\_\_ Can we leave a message at this number? Y. N

Email Address: \_\_\_\_\_

Blood Type: \_\_\_\_\_

Current Weight: \_\_\_\_\_ What do you consider a good weight for yourself now? \_\_\_\_\_

Do you use any of the following?

Cigarettes or tobacco: Y N How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Marijuana or other drugs: Y N Frequency: \_\_\_\_\_ For how long? \_\_\_\_\_

Alcohol: Y N Drinks per day/week? \_\_\_\_\_

History of alcohol addiction: Y N

History of eating disorder: Y N

Are you allergic to any medications? If so which one(s) and what is your reaction?

Are you affected by any specific allergies? If so, which ones, how strong and how often?

Dust	<input type="checkbox"/>	Mild	Moderate	Severe		Infrequent	Occasional	Frequent
Pets	<input type="checkbox"/>	Mild	Moderate	Severe		Infrequent	Occasional	Frequent
Pollens	<input type="checkbox"/>	Mild	Moderate	Severe		Infrequent	Occasional	Frequent
Flowers	<input type="checkbox"/>	Mild	Moderate	Severe		Infrequent	Occasional	Frequent
Nuts	<input type="checkbox"/>	Mild	Moderate	Severe		Infrequent	Occasional	Frequent
Strawberries	<input type="checkbox"/>	Mild	Moderate	Severe		Infrequent	Occasional	Frequent
Other	<input type="checkbox"/>	_____						

Are you taking any nutritional supplements? (Please include all vitamins and herbal supplements) If so which one(s)?

Do you feel/ believe that the use of supplements could help to relieve your symptoms? Y N

**Toxin Exposure**

Did you grow up near any refinery, polluted area or in a home with lead paint? If so, what sort of pollution were you exposed to? \_\_\_\_\_

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials? \_\_\_\_\_

Are you particularly sensitive to perfumes, gasoline, or other vapors? \_\_\_\_\_

Do you use pesticides, herbicides or other chemicals around your home? \_\_\_\_\_

What estimated percentage of your meals are home cooked? \_\_\_\_\_

Where do the rest of them come from? (i.e., restaurants, fast food, processed meals, etc.)

Are you currently dealing with any digestive issues? If so, how does that affect your daily living?

On a scale 1-10 what is your present energy level? 1 2 3 4 5 6 7 8 9 10

Energy level 1 year ago \_\_\_\_\_ Energy level 5 years ago \_\_\_\_\_

What time of day do you have the most energy? Morning Afternoon Evening

What time of day do you have the least amount of energy? Morning Afternoon Evening

During the first 30 minutes after waking up in the morning, I usually feel:

Very Groggy

Slightly Drowsy

Slightly Drowsy but Awake

Alert

Please place a check beside any of the following statements that are true for you:

\_\_\_\_\_ I feel that sleep is a waste of time

\_\_\_\_\_ I enjoy sleeping very much

\_\_\_\_\_ I often wake up in the middle of the night for various reasons

\_\_\_\_\_ I get approximately 7-8 hours of restful sleep

\_\_\_\_\_ I refer to myself as a coffee drinker as I rely on it to rise in the morning

How would you describe your memory strength? (Please describe how memory currently affects your daily living. Do you feel there's room for improvement?) \_\_\_\_\_

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Do you experience any of the following moods on a regular basis? (Please circle all that apply)

Anxiety

Irritability

Depression

Panic

Shame

How committed are you towards making changes in your health:

Little

Moderate

Very

0

1

2

3

4

5

6

7

8

9

10

Is there anything regarding your health/nutrition or any other questions you have that you would like to discuss? \_\_\_\_\_

In the future, if there are any changes to the information you have provided, please do not hesitate to let us know immediately.



**ANDERSON  
CHIROPRACTIC  
and Massage**

Date: \_\_\_\_\_

I \_\_\_\_\_ do hereby give my  
(patient name)  
consent to Anderson Chiropractic and its representatives to take x-rays as deemed  
appropriate by the examining doctor of chiropractic. I also hereby declare that, to  
my knowledge, I am not pregnant.

\_\_\_\_\_  
Patient Signature/ Guardian Signature (relationship)

# ADVANTAGE RADIOLOGY SERVICE

(419) 269-2424

(844) 283-4163

PATIENT \_\_\_\_\_ CLINIC \_\_\_\_\_ FILM DATE \_\_\_\_\_  
AGE \_\_\_\_\_ SEX M  F  SOCIAL SECURITY # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
PATIENT ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the clinic where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Workers' Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to Advantage Radiology Service (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third-party payer. I authorize my treating physician, insurance company, attorney, and/or any third-party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for the services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

### **PATIENT HISTORY**

PATIENT PRESENTATION \_\_\_\_\_

TRAUMA? YES  NO  EXPLAIN \_\_\_\_\_

PAST MEDICAL HISTORY \_\_\_\_\_

MALIGNANCY? YES  NO  DETAILS \_\_\_\_\_

DIAGNOSIS/CONCERNS/QUESTIONS [NO ICD CODES PLEASE] \_\_\_\_\_

PLEASE COMPLETE INSURANCE/BILLING INFO ON REVERSE SIDE



**ANDERSON  
CHIROPRACTIC  
and Massage**

Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Claim Group: \_\_\_\_\_ S.S.#/ID#: \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ Insurance Co. to pay by check made out and mailed to:

Anderson Chiropractic  
4044 McLean Dr.  
Cincinnati, OH 45255

or

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Anderson Chiropractic  
4044 McLean Dr.  
Cincinnati, OH 45255

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Today's date: \_\_\_\_\_

Signature of Patient Policyholder: \_\_\_\_\_

Name/ Relationship to patient, if minor: \_\_\_\_\_

Staff Witness: \_\_\_\_\_

Signature of Claimant, if other than Policyholder: \_\_\_\_\_

### **Patient-Doctor Agreement**

The purpose of these agreements is to allow us to more completely serve you and to get the best results in the shortest amount of time. It is our experience that those who adhere to the following agreements get the best results.

### **Signing In**

When you arrive, please sign in at the front desk. You will be called and assigned a treatment room on or around your appointment time. Other patients may be called before you because their appointment time is before yours, the particular services being received that day or their provider may be available before yours. Please be aware that if you show up earlier than your appointment time that does not mean the doctor will see you any earlier however, depending on the schedule that day it may be a possibility but please do not expect this. We advise that if you desire an earlier appointment time, to call that morning and see if any earlier times are available. When you approach the assigned treatment room, place your folder in the tray on the wall directly outside of your room. Have a seat inside the room and the doctor will be in asap. The Provider's in this office do their best to run on time however it does happen that they fall behind schedule. If you need to leave, no problem. Please see the front desk to reschedule your appointment.

### **New Injuries/Car Accidents**

In the event you sustain a new injury please let the front desk know as soon as possible. There may be additional paperwork to be filled out. In addition, it's crucial that you inform us if you were in a car accident no matter how minor the injuries/damages are, as there will be additional paperwork to fill out. In the event that you wait until your adjustment appointment to notify us of an injury/accident, the appointment will most likely need to be rescheduled as we need an extended amount of time. Please be aware that the doctor may deem it necessary for new x-rays at any time. In addition to that, the doctor can refuse to adjust you if they find it medically appropriate to have x-rays completed.

### **Payment of Bills**

We expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our office manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. This is achieved by paying for services the day they are rendered unless prior arrangements are made. If this is not done, a \$5.00 fee is added to that original amount. If your balance is maintained over a 30 day period without any type of payment, a 2% interest charge will be applied to the past due amount every 30 days. Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. Therefore, although we will prepare the insurance forms, the patient is responsible for payment of services rendered. We do accept certain insurance assignments; however, all insurance assignments must be approved in advance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect the patient to call the insurance company on our behalf to help get the claim resolved and paid. If an insurance company sends a check to your home, it should be brought to our office as soon as possible. Please also bring in the attached explanation of benefits.

## **Appointment Reminders**

The text reminders go out around the hour of 8am the morning of your appointment. This service is a courtesy to our patients to help you keep your schedule on track; however do not depend on this! While it doesn't happen often, technology sometimes doesn't cooperate to perfection. If you do not receive your appointment reminder it could mean that the system is down **or** that you're in fact not on the schedule. It's best to call our office when you do not get a reminder to be sure you have an appointment that day. In addition, we're human at this office so please follow the time your reminder says.

## **Rescheduling/scheduling appointments**

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get the result we both desire. If you need to change the day/time of your appointment, please notify our office as far ahead as possible. When an appointment cannot be kept on that same day, please call our office by 9:00am the morning of your appointment (or at least 4 hours before your appointment) or a **\$20 fee** will be applied to your account. This amount will **NOT** be submitted to your insurance, as it is the patient's responsibility. If you're a massage patient as well, please note that the same policy is in place however, the fee is **half** the cost of the massage. If you find yourself running 5+ mins late for your appt, please call/text our office to notify us. If you're 10+ mins late without notifying our office, it may result in your appointment being automatically cancelled. This situation causes the doctor to run behind and we must keep things timely. The doctor's schedule books rather quickly so we must keep cancelling appointments to a minimum but we understand it does happen. However, if you excessively cancel, this may result in dismissal from our office. We ask that you arrive a minimum of 5 minutes before your appointment time; this is to keep things running smoothly for both the patients and the doctor.

**If the appointment you're requesting to cancel is a RE EXAM appointment or any other specific appointment that requires an extra block of time, you must give a minimum of 24 hours notice or a missed appointment fee will be applied to your account.**

## **Concerns**

We are here to serve you. Please speak with the staff or the doctor about anything that could be upsetting you (i.e. long waits, staff insensitivity, and treatment confusion.) We see your comments as helping us to help you and others.

## **Use of cellular phones, pagers and any other electronic devices**

The use of cellular phones, pagers and any other electronic devices in the adjustment/treatment rooms is strictly prohibited unless an emergency situation exists. If you **MUST** use these devices while in the waiting room, please exercise common courtesy by keeping your phone volume, voice and tone in a low, conversational manner.

## **Our Personal Concern:**

Our professional and personal concern is your health and our reputation. Therefore, we accept only those patients whom we sincerely believe we can help.

I, the undersigned, have read and agree to the patient office policies presented to me at Anderson Chiropractic.

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Patient Signature

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Date



**ANDERSON  
CHIROPRACTIC  
and Massage**

Authorized Contact Persons

I, \_\_\_\_\_ give the doctors and staff of Anderson Chiropractic  
Patient Name  
 permission to speak with the following person(s) for the following reason(s); which may include, but are not limited to the following: Appointment scheduling or rescheduling, billing or balance inquiries, leaving messages with them from us, and allowing them to leave messages at Anderson Chiropractic for me.

	<u>Name</u>	<u>Phone Number</u>	<u>Relationship to Patient</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

I have read and agree to the above statements. I understand that this allows the doctors and the doctors' staff to speak to the above-mentioned person(s) about my personal health information. I take full liability of any breach of my privacy rights and do not hold Anderson Chiropractic responsible.

Signature: \_\_\_\_\_

Relationship, if minor: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Witness: \_\_\_\_\_

Date: \_\_\_\_\_



**ANDERSON  
CHIROPRACTIC**  
and Massage

**Patient Contact Approval**

I, \_\_\_\_\_ (patient name) give the doctors and staff of Anderson Chiropractic the right to contact me either in written form or in vocal communication in the following ways and for the following purposes (please initial on the applicable line); Promotional items are those offered by Anderson Chiropractic only (no outside contact). **INITIAL**

<u>Type</u>	<u>Yes</u>	<u>No</u>
1. Promotional telephone calls	_____	_____
2. Promotional e-mails E-mail address: _____	_____	_____
3. Mailed birthday cards *(includes adjustment coupon)*	_____	_____
4. Mailed holiday cards	_____	_____
5. Mailed patient referral card *(includes free adjustment)*	_____	_____
6. Mailed "Welcome to our office" letter	_____	_____
7. Promotional & specials mailers *(i.e. Teddy Bear Days cards)*	_____	_____

May Anderson Chiropractic leave voicemails at the phone number(s) you have provided? Y or N (circle)  
Initial: \_\_\_\_\_

Appointment reminder preference: (initial all that are desired)  
 \_\_\_\_\_ Initial here if you would like reminder via Phone call  
 \_\_\_\_\_ Initial here if you would like reminder via Text, specify Phone Carrier \_\_\_\_\_  
 \_\_\_\_\_ Initial here if you would like reminder via Email  
 \*\*\*\*\* \_\_\_\_\_ Initial here if you give permission for Anderson Chiropractic to contact you via text/email regarding appointments and other basic information. By initialing, you leave it to the discretion of the doctor and staff to decide what is appropriate to communicate in the aforementioned ways.

This and all information will be kept in the strictest of confidence and will not be passed to any outside entities.

\*\* (Federal Law prohibits Medicare/ Medicaid participation)

I have read and agree to the above statements. I understand that this allows the doctors and the doctors' staff to contact me at these times. If I do not wish to be contacted in these ways, I will discuss with the doctor/staff how to be reached for these purposes.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date: \_\_\_\_\_ Staff Witness: \_\_\_\_\_

I have read and understand the front and back pages of the **Informed Consent to Chiropractic Treatment** as presented to me at Anderson Chiropractic.

\_\_\_\_\_ (initials) I have refused the offer of my own copy of these pages.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Witness: \_\_\_\_\_ over →

## Informed Consent to Chiropractic Treatment

The primary treatment used by the doctors of Anderson Chiropractic is the spinal adjustment. This is the treatment of choice in the Chiropractic field.

**The nature of the Chiropractic adjustment.**

With the use of our hands, mechanical devices and specific treatment tables, we will use passive movements to move joints of the spine and other associated structures (i.e. the extremities) with the purpose of restoring joints to their proper physiological relationship of motion and related function.

**The material risks inherent in the Chiropractic adjustment.**

Complications of the Chiropractic adjustment include: fracture, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have lead to injuries to the arteries in the neck which could lead to serious complications including stroke. Also reported by patients is feeling of soreness and stiffness in the neck.

**The probability of those risks occurring.**

In order to avoid the rare occurrence of the risks associated with Chiropractic adjustment, a thorough history, examination, and x-rays are taken. Although the risk of stroke is rare, within the examination, tests are performed to help alleviate its occurrence.

**The availability and the nature of other treatment options.**

Other treatment options include but are not limited to; Self-administered, over-the-counter analgesics and rest, Medical care with prescription drugs, (i.e. anti-inflammatory, muscle relaxants, and pain killers), hospitalization with traction or surgery.

**The material risk in such options and the probability of such risks occurring.**

Professional literature describes the effects of prolonged over-the-counter and prescription drugs to be undesirable, and have proven that rest is not an appropriate source of relief due to impracticality; most people return to work prematurely and cause further damage and actually extend their recovery time. Most of these complications are dependent on the patients' general health, pain tolerance, and self discipline not to over use the drug.

**The risk and dangers attendant to remaining untreated.**

Remaining untreated allows further formation of adhesions which could lead to a reduction of mobility and set up a pain reaction. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

**Do you understand the above, or do you have any questions? List any questions and if they are resolved** \_\_\_\_\_



**ANDERSON  
CHIROPRACTIC  
and Massage**

**Informed Consent to Auxiliary Treatment**

In addition to the Chiropractic adjustment, we intend to use the following treatments; also listed are the uses and benefits of such treatments. Treatments only apply to those marked by the doctor.

**Interferential**

**Uses:** For pain relief, swelling, ligament sprains, muscle strains and spasm.

**Benefits:** Reduction of painful symptoms and local swelling, promotes muscle tone and helps restore normal movements, aides the body by releasing the body's natural pain killers and accelerating the healing process.

**Risk involved:** Skin reactions, spread of unknown infection or cancer, small risk of electrical shock, may interfere with blood pressure if used in cervical area.

**Ultrasound**

**Uses:** For muscle spasm, massage damaged tissue, break up calcium deposits.

**Benefits:** Stimulate healing, speeds metabolism and improves blood flow, reduce nerve root irritation.

**Risks involved:** Periosical burns, skin reactions, dissemination of unknown infection.

**Superficial Heat**

**Uses:** Calm tissues suffering from long term spasms or irritation, increase in flexibility and range of motion.

**Benefits:** Increase circulation, relax muscle tension, reduce joint stiffness, and prepare tissues for rehabilitation.

**Risks involved:** 1<sup>st</sup> and 2<sup>nd</sup> degree burns, hemorrhage.

**Cryotherapy**

**Uses:** Reduce local swelling of inflamed tissues.

**Benefits:** Reduce swelling, numb area to reduce pain, reduce muscle spasms.

**Risks involved:** Skin reactions.

**Trigger point Therapy**

**Uses:** Reduce muscle spasms, relax hyperactive muscles, help restore normal range of motion, promote faster healing.

**Benefits:** Reduce chronic muscle spasms, avoid scar tissue formation, improve muscle tone, promotes better circulation.

**Risks involved:** Bruising, release of emboli.

**Exercise Therapy**

**Uses/Benefits:** Increase range of motion, retrains damaged muscles, strengthens spinal structure, speeds rehabilitation, help adjustment hold.

**Risks involved:** Limited to the general health of patient, and controlled by patient judgment, following instruction given by doctor.

Do you understand the ancillary treatments and risks described? \_\_\_\_\_

Are there any questions? (resolved) \_\_\_\_\_