Anderson Chiropractic

General Information

Name ______________________ **Social Security #** __________
Address __________ **City** __________ **State** ____ **Zip** ______
Home Phone __________ **Cell Phone** __________
Email ______________________
Employer __________ **Occupation** __________
Business Address __________ **City** __________ **State** ____ **Zip** ______
Business Phone __________ **Business Email** __________
Emergency Contact __________ **Phone #** __________
Age ______ **Birth Date** ______ **How many Children?** ______
Marital Status · Single · Married · Widowed · Separated · Divorced
Sex · Male · Female
Race · American Indian · Alaska Native · Asian · Black or African American · Native Hawaiian · Other Pacific Islander · white · Decline to answer
Ethnicity · Decline to answer · Hispanic or Latino · Not Hispanic or Latino
Language ______________________
Who may we thank for referring you? ______________________

Primary Insurance

Relation to Patient: · Self · Husband · Wife · Child · Other
Name ______________________
Address __________ **City** __________ **State** ____ **Zip** ______
Birth Date __________ **Cell Phone** __________
Sex · Male · Female
Employer __________ **Address** __________
Insurance Company ______________________
Phone Number ______________________
Insurance ID __________ **Group #** __________
Secondary Insurance · Yes · No

Reason for Visit

Your reason for ***this*** visit: ______________________
Please describe current pain and its location: ______________________
Are your current symptoms a result of an auto or other accident? __________
When did symptoms begin (date)? __________
Have you had a similar condition in the past? · Yes · No
Is the pain getting: · Worse · Better · Same · Comes and goes
How often do you have this pain? ______________________
Have you been treated by a medical physician for this condition? __________
If so, when and where? ______________________
Activities that are difficult to perform: · Sitting · Walking · Bending · Lying down · Lifting
Type of pain: · Sharp · Dull · Throbbing · Aching · Burning · Tingling · Numbness · Cramping · Stiffness · Swelling · Other __________
Is the pain interfering with: · Work · Sleep · Daily Routine · Recreation
Have you ever seen a Chiropractor? · Yes · No If yes, when and why? __________

Health History

Please List any medications (including over the counter) that you are taking: ________

____

Do you have any allergies to medication? · Yes · No

If yes, please list allergies: ____

____

Please list any serious injuries, broken bones or surgeries you have had in the last 10 years:

Description	Date

Women: Are you pregnant? · Yes · No If so, how far along? _____ Nursing · Yes · No

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- Heart Attack/Stroke
- Congenital Heart Defect
- Fainting/Seizure/Epilepsy
- Shingles
- Psychiatric problems
- Hepatitis
- Anemia
- Artificial Bones/Joints
- Digestive Issues
- Arthritis
- Neck Pain
- Jaw Pain
- Dizziness
- Emphysema
- Glaucoma
- Earaches
- Cancer
- Ringing in the ears
- Headaches
- Diabetes
- Wrist/Shoulder/Arm pain
- Leg Pain
- Lower back problems
- Kidney Problems
- HIVPositive/AIDS
- Ulcer/Colitis
- Gout
- Numbness, Where? ________
- Tingling, Where? ________
- Muscle Spasms, Where? ________

Personal Habits

Alcohol	· Yes · No	How much? ________________
Exercise	· Yes · No	How often? ________________
Sleep	· Normal · Interrupted	Please Explain ________________
Tobacco	· Yes · No	If yes, how many packs per week? ________

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Susan A. Anderson, D.C. to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status I will inform Susan A. Anderson, D.C. I authorize my insurance company to pay Susan A. Anderson, D.C. all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the Susan A. Anderson D.C. to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. It is understood that any and all X-Ray taken will remain a permanent record of Susan A. Anderson D.C .

Signature: ____ Date: ________

Payment is due at time of treatment unless prior arrangements have been approved