ANDERSON CHIROPRACTIC, LLC
Dr. Donald J. Anderson D.C.
PO Box 181, 2577 Hartford, Ave, Wilder, VT 05088
(P): 802-295-29360 (F): 802-295-9361
www.andchiro.com

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

________________________ **Today's Date (MM/DD/YYYY)**

Have you consulted a chiropractor before?
NO ☐ YES ☐ When?____________________

________________________ **Whom may we thank for referring you?**

________________________ **If so, whom?**

Gender
Male ☐ Female ☐

________________________ **Your Last Name**

______/______/______ **Your Social Security Number**

________________________ **Your First Name & Middle Initial**

____/____/______ **Birth Date**

________________________ **Spouse's Name**

______-______-______ **Spouse's Phone No.**

________________________ **Address**

Marital Status: Single ☐ Married ☐ Widowed ☐ Separated ☐ Student ☐

________________________ **City**

________________ **State**

________________ **Zip Code**

______-______-______ **Home Phone**

________________________ **Email address**

______-______-______ **Work Phone**

______-______-______ **Cell Phone**

________________________ **Emergency Contact & Phone No.**

________________________ **Employer**

________________________ **Occupation**

________________________ **Insurance Carrier**

________________ **ID No.**

________________ **Group No.**

________________________ **Insurance Phone No.**

________________________ **Policy Holders Name**

________________ **Holders Relationship to you**

________________ **Their Date of Birth**

________________________ **Their address if different than yours**

- If you do not have insurance **ALL** payments are expected at the time of service.
- If you have insurance **ALL COPAYS** are due at time of service
- There will be a 1.5% finance charge added to all balances after 60 days
- There will be a $25.00 charge on all returned checks.

I have read and understand ANDERSON CHIROPRACTIC, LLC's office policies and will honor them.

Signature:________________________________

Assignment of Release: I certify that I, and/or my dependant(s), have insurance coverage with ________________and assign directly to Dr. Donald J. Anderson D.C. all insurance benefits, if any, otherwise payable by me for services rendered. I understand I am financially responsible for all not paid for by my insurance and if in default will be sent to collections, an additional 66.7% will be applied to my bill.

Signature:________________________________

Privacy Policy: I understand and have been provided with a "Notice of information Practices" that provides a more complete description of information for directory uses and disclosures.

Healthcare Authorization - Allows the doctor and staff to work on you.

Signature:________________________________

Signature:________________________________

IS THIS AN ACCIDENT OR WORKERS COMPENSATION VISIT? If so, please notify the staff for additional required paperwork.

MEDICATION LIST

Name of Drug	Dosage (mg, IU)	Time take per day	Reason for taking medication

PATIENT HISTORY

Patient Name__________________________________ DOB: ____ /_____ /_________

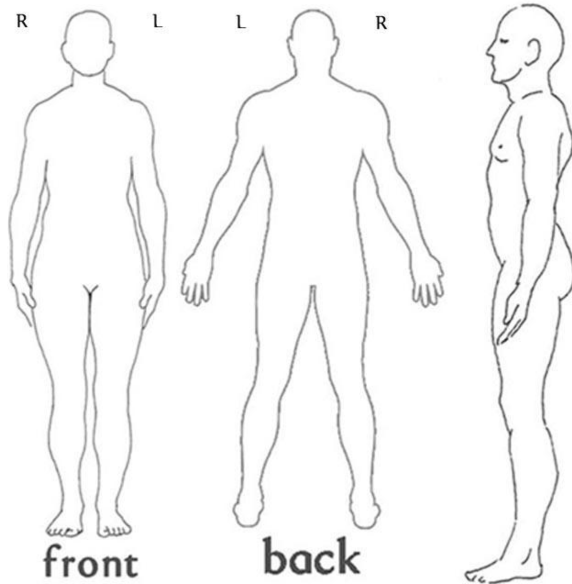
Date: ____ /_____ /_________ Age: _____________

ANDERSON CHIROPRACTIC, LLC
Dr. Donald J. Anderson D.C.
PO Box 181, 2577 Hartford, Ave
Wilder, VT 05088
(P): 802-295-29360 (F): 802-295-9361
www.andchiro.com

Show area (s) of Pain or unusual Feeling

Mark the areas on the body where you feel the described sensations. Use the appropriate symbols. Mark all areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - -	000000000000	XXXXXXXXX	*******	/ / / / / / / / / / / / /



Please mark on the pain scale from 0 to 10 the you feel with this condition, 10 being the worst pain you have felt with this condition.

PAIN SCALE

Neck-Shoulder-Arm Pain
On a scale of 0 - 10
I rate my discomfort as follows
0--10

Mid-Back Pain
On a scale of 0 - 10
I rate my discomfort as follows
0--10

Lower Back Pain
On a scale of 0 - 10
I rate my discomfort as follows
0--10

Please circle the area of discomfort and describe the pain.

Acute ___ Chronic ___ Sharp ___ Burning ___ Moving ___ Tingling ___ Dull ___
Severe ___ Stabbing ___ Shooting ___ Throbbing ___ Numbness___

What relieves the pain: ____

What aggravates the pain: ____

Date: ____________________________________

Signature:____

PATIENT HISTORY

ANDERSON CHIROPRACTIC, LLC
Dr. Donald J. Anderson D.C. PO Box 181, 2577 Hartford, Ave
Wilder, VT 05088
(P): 802-295-29360 (F): 802-295-9361
www.andchiro.com

Patient Name___________________________________ DOB: ____ /_____ /_________

Date: ____ /_____ /_________ Age: _____________

Chief complaint:____

Date of Onset:_____/_______/______ Was the Onset; Gradual ☐ Sudden ☐ Since Onset, has it gotten worse? YES ☐ NO ☐

Describe what caused the pain:____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMLAINT:**

Describe the quality of the complaint/pain:
- ☐ Sharp
- ☐ Dull/Ache
- ☐ Throbbing
- ☐ Tingling/Numbness

Other:_________________________

Describe if pain is in a single spot or does it spread out:
- ☐ Radiation dull, deep ache
- ☐ Pin point
- ☐ Burning, sharp stabbing, tingling, numb

Other:_________________________

How often are you aware of the pain:
- ☐ Intermittent (less than 25% of the time when awake)
- ☐ Occasional (25-50% of the time when awake)
- ☐ Frequent (50-75% of the time when awake)
- ☐ Constant (75-100% of the time when awake)

Other:_________________________

Does any of the following make the pain worse:
- ☐ Lifting/bending/pushing/pulling
- ☐ Cough/Sneeze/Bowel Movement
- ☐ Driving/Riding/Sitting
- ☐ Walking/Running/Standing

Other: _________________________

Does any of the following make it better:
- ☐ Rest/Laying down
- ☐ Sitting
- ☐ Walking/Exercise

Other: _________________________

Does it interfere with your daily activities:
- ☐ Minimal (annoyance, no impairment)
- ☐ Slight (tolerated, some impairment)
- ☐ Moderate (marked impairment)
- ☐ Marked (preclude any activities)

Have you detected any possible relationship of your current complaint with any of the following:

☐Muscle Weakness ☐ Bowel/Bladder ☐ problems ☐ Digestion ☐ Cardiac/Respiratory ☐ Other: _________________________

Have you tried any self-treatment or taken any medication (over the counter or prescription):☐ YES ☐ NO
If yes, explain the results:____

Have you ever experienced your present problem before consulting Anderson Chiropractic?☐ YES☐ NO If yes, when?_________________

Was treatment provided:☐ YES☐ NO If yes, by whom:______________________________ Outcome: ___________________________

How do you sleep: ☐ Back☐ Side ☐ Stomach Do you use a pillow:☐YES ☐NO Are you currently pregnant?☐ YES ☐ NO

Do you wear orthotics or arch supports?☐ YES ☐ NO

Are you currently taking anti-coagulant or blood thinning medications? ☐ YES ☐ NO

What type of care are you interest in:☐ Pain relief only ☐ Healing of current condition☐ Optimizing your health ☐ All three

Date: ____________________________ Signature:____