Anderson Chiropractic

of Oshkosh

Brian L. Anderson, DC

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NAME _____ **EMAIL** _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

PHONE # (CELL) _____ **(HOME)** _____

AGE _____ **BIRTHDATE** _____ **SOCIAL SECURITY #** _____

MARTIAL STATUS M S W D NUMBER OF CHILDREN _____

EMPLOYER _____ **OCCUPATION** _____ **WORK PHONE #** _____

NAME OF SPOUSE _____ **SPOUSE'S PHONE #** _____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE NOTIFY? _____**PHONE #**_____

WHO REFERRED YOU?/HOW DID YOU FIND OUT ABOUT US? _____

AUTHORIZATION AND RELEASE

Payment of deductible and insurance co-pays are due at the time of service, unless other arrangements have been made. It is the responsibility of the patient to keep their account current.

I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment below. I also authorize payment of medical benefits to the undersigned physician or supplier for services described on the insurance claim form.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that Anderson Chiropractic will credit my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment that fees for professional services rendered me will be immediately due and payable.

SIGNATURE _____ **DATE** _____

(FOR CONSENT OF A MINOR PLEASE ALSO READ AND SIGN BELOW)

I hereby authorize the above-mentioned office to administer chiropractic care (which may include exam, x-ray, adjustments, and/or therapy) as they deem necessary to my child.

GUARDIAN SIGNATURE _____ **DATE** _____

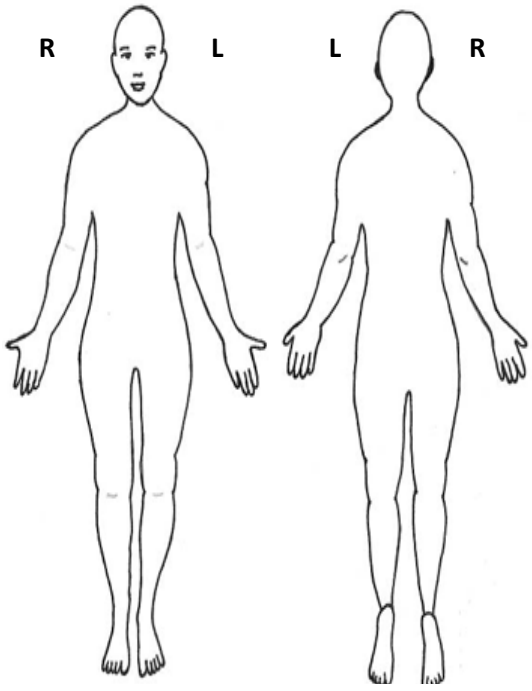
Anderson Chiropractic of Oshkosh

Name _____ Account # _____ Date _____ Doctor Initials _____

Present Complaints: Please check all answers and fill in the blanks where appropriate. The information you provide will assist Dr. Anderson in obtaining an early understanding of your condition. In the spaces below, please describe the present, major complaint which brought you to this clinic for care.

Chief complaint/Purpose of this appointment: _____
Date symptoms appears or how long have you had this complaint: _____
Is this a work related injury? Yes _____ No _____ Is this a motor vehicle accident? Yes _____ No _____
If your complaint began after a specific incident, please explain:
_____
_____
_____

Please use the picture below to **SHADE IN** the area(s) of pain as if another person could actually see your pain. Using the pain descriptors given, list the descriptors outside of the body and draw a line to the associated area.



Pain Descriptors:

Sharp = S	Shooting = Sh
Sore = So	Strained = Str
Ache = A	Burning = B
Tight = T	Pounding = P
Kink = K	Throbbing = Th
Dull = D	Pressure = P
Knot = Kn	Stabbing = St
Pins & Needles = P&N	

Complaint #1 _____
Rate the severity of you pain at its least and greatest by circling TWO numbers:

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Moderate Severe Excruciating Pain

Rate the percentage of time that you are aware of your pain while you are awake.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Never Continuous

Complaint #2 _____
Rate the severity of you pain at its least and greatest by circling TWO numbers:

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Moderate Severe Excruciating Pain

Rate the percentage of time that you are aware of your pain while you are awake.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Never Continuous

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FAMILY HISTORY

Have your parents, grandparents, uncles, aunts, brothers, sisters, or children ever been treated for any of the following?

Arthritis	Y		Cancer	Y		Migraine Headaches	Y	
Allergies	Y		Convulsions	Y		Mental Illness	Y	
Asthma	Y		Diabetes	Y		Lung Disease	Y	
Birth Defects	Y		Heart Disease	Y		Tuberculosis	Y	
Blood Disease	Y		High Blood Pressure	Y		Twins	Y	
Bleeding Tendency	Y		Kidney Disease	Y		Endometriosis	Y	

LIFESTYLE HABITS (circle those that apply)

Smoking None How many per day _____ Years _____

Alcohol Never Social Light Moderate Heavy

Coffee - Cups per day _____ Pop - Cans per day _____

Exercise _____ What Type _____ How Often _____

Exercise _____ What Type _____ How Often _____

Chiropractors you have seen before:

Name _____ Condition _____ City, State _____ When _____

Name _____ Condition _____ City, State _____ When _____

Name _____ Condition _____ City, State _____ When _____

List all surgeries:

Type _____ Surgeon _____ When _____ Hospital _____

Type _____ Surgeon _____ When _____ Hospital _____

Type _____ Surgeon _____ When _____ Hospital _____

Past accidents or injuries: (car, work, sport, recreational, etc.)

Type _____ When _____ Treatment? Yes ____ No ____

Type _____ When _____ Treatment? Yes ____ No ____

Type _____ When _____ Treatment? Yes ____ No ____

List medications you are currently taking (prescription and over-the-counter):

Type_____ For _____ Type_____ For _____

Type_____ For _____ Type_____ For _____

Type_____ For _____ Type_____ For _____

Obstetric history (birth history – ladies only):

Date _____ Birth Wt. _____ Hrs. of Labor _____ Hospital _____

Date _____ Birth Wt. _____ Hrs. of Labor _____ Hospital _____

Date _____ Birth Wt. _____ Hrs. of Labor _____ Hospital _____

Use back of page is additional space is needed.

ANDERSON CHIROPRACTIC OF OSHKOSH S.C.

Brian L. Anderson, DC

For Pain Relief and Better Health Naturally

INFORMED CONSENT

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. However, it has one of the safest records of the wide range of treatments that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications verses the relative frequency of the complications of the other typical treatments, which may be used for spinal disorder.

Disc injury from manipulation causing spinal cord pressure: 1 per 100 million
Artery injury from manipulation causing stroke: 1 per million

Neuralgic complication from neck surgery: 1 per 64
Neuralgic complication from back surgery: 1 per 333
Death rate from neck surgery: 1 per 145

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs. These drugs cause fairly common and potentially serious complications.

Complications associated with anti-inflammatory drug use:

Serious stomach or intestinal bleeding: 1-4 per 1000 users
Hospitalizations from complications: 20,000 per year
Deaths from complications: 2,600 per year

I have read the above and understand the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Anderson Family Chiropractic, S.C.

Name_____ Signature _____ Date_____

Parent / Guardian_____ Signature _____ Date_____

Anderson Chiropractic of Oshkosh

Name _____ **Account #** _____ **Date** _____ **Doctor Initials** _____

Review of Body Systems

Check only those conditions that apply. If not applicable, leave blank.

Common Conditions	Past	Present		Musculoskeletal	Past	Present	
	[ ]	[ ]	High Blood Pressure		[ ]	[ ]	Neck Pain/Stiffness
	[ ]	[ ]	High Cholesterol		[ ]	[ ]	Mid-Back Pain
	[ ]	[ ]	Diabetes Type 1		[ ]	[ ]	Low Back Pain
	[ ]	[ ]	Diabetes Type 2		[ ]	[ ]	Shoulder Blade Pain
	[ ]	[ ]	Sleep Apnea		[ ]	[ ]	Bursitis
	[ ]	[ ]	Hypothyroidism		[ ]	[ ]	Scoliosis/Spinal Curvature
	[ ]	[ ]	Sinus Infections		[ ]	[ ]	Osteoporosis
	[ ]	[ ]	Anxiety/Depression		[ ]	[ ]	Sciatica
	[ ]	[ ]	UTI (urinary tract infection)		[ ]	[ ]	Poor Posture
	[ ]	[ ]	GERD (Heartburn)		[ ]	[ ]	Rheumatoid Arthritis
	[ ]	[ ]	Difficulty Sleeping		[ ]	[ ]	Foot Trouble
	[ ]	[ ]	Arthritis		[ ]	[ ]	Carpal Tunnel
	[ ]	[ ]	COPD		[ ]	[ ]	Hernia
General	**Past**	**Present**		**Eyes, Ears, Nose & Throat**	**Past**	**Present**	
	[ ]	[ ]	Allergies		[ ]	[ ]	Near Sighted
	[ ]	[ ]	Chills		[ ]	[ ]	Far Sighted
	[ ]	[ ]	Convulsions		[ ]	[ ]	Deafness
	[ ]	[ ]	Dizziness		[ ]	[ ]	Ear Discharge
	[ ]	[ ]	Fainting		[ ]	[ ]	Earaches
	[ ]	[ ]	Fatigue		[ ]	[ ]	Nose Bleeds
	[ ]	[ ]	Fever		[ ]	[ ]	Asthma
	[ ]	[ ]	Headaches		[ ]	[ ]	Colds
	[ ]	[ ]	Neuralgia		[ ]	[ ]	Sore Throat
	[ ]	[ ]	Dizziness		[ ]	[ ]	Hoarseness
	[ ]	[ ]	Sweats		[ ]	[ ]	Enlarged Glands
	[ ]	[ ]	Tremors		[ ]	[ ]	Dental Decay
	[ ]	[ ]	Numbness		[ ]	[ ]	Gum Troubles
Genito-Urinary	**Past**	**Present**		**Gastrointestinal**	**Past**	**Present**	
	[ ]	[ ]	Bedwetting		[ ]	[ ]	Belching or Gas
	[ ]	[ ]	Blood in Urine		[ ]	[ ]	Colitis
	[ ]	[ ]	Frequent Urination		[ ]	[ ]	Constipation
	[ ]	[ ]	Kidney Infection		[ ]	[ ]	Diarrhea
	[ ]	[ ]	Painful Urination		[ ]	[ ]	Difficult Digestion
	[ ]	[ ]	Pus in Urine		[ ]	[ ]	Gallbladder Trouble
	[ ]	[ ]	Prostate Trouble		[ ]	[ ]	Hemorrhoids
	[ ]	[ ]	Inability to Control Bladder		[ ]	[ ]	Intestinal Worm
	[ ]	[ ]	Painful Menstruation		[ ]	[ ]	Jaundice
	[ ]	[ ]	Hot Flashes		[ ]	[ ]	Liver Trouble
	[ ]	[ ]	Irregular Cycle		[ ]	[ ]	Nausea/Vomiting
	[ ]	[ ]	Lumps in Breasts		[ ]	[ ]	Stomach Pain
	[ ]	[ ]	Bladder Infections		[ ]	[ ]	Vomiting Blood
Cardiovascular	**Past**	**Present**		**Respiratory**	**Past**	**Present**	
	[ ]	[ ]	Hardening of Arteries		[ ]	[ ]	Chest Pain
	[ ]	[ ]	Low Blood Pressure		[ ]	[ ]	Chronic Cough
	[ ]	[ ]	Pain Over Heart		[ ]	[ ]	Difficulty Breathing
	[ ]	[ ]	Poor Circulation		[ ]	[ ]	Spitting Up Blood
	[ ]	[ ]	Rapid Heart Beat		[ ]	[ ]	Spitting Up Phlegm
	[ ]	[ ]	Slow Heart Beat		[ ]	[ ]	Wheezing
	[ ]	[ ]	Swelling of Arteries				