CONFIDENTIAL HEALTH INFORMATION

Anderson Chiropractic, LLC
Donald J. Anderson, D.C.
PO Box 181, 2577 Hartford Ave, Wilder, VT 05088
802-295-9360 (P) 802-295-9361 (Fax)
www.andchiro.com

Date: _____/_____/_____

Patient Name:____ **DOB:**_____/_____/____

How did you hear about us? ____________________________

Have you ever been to a chiropractor? When? ____

Financial Policy:

- For individuals without insurance, **ALL PAYMENTS** are due at the time of service.
- For individuals with insurance, **ALL COPAYS** are due at time of service
- There is a $25.00 charge on all returned checks.

I have read and understand Anderson Chiropractic's Financial Policy.

Signature:______________________________________

Assignment of Release: I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Anderson for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

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.

Signature:______________________________________

Healthcare Authorization - I give my consent for treatment from Dr. Anderson and staff.

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

Do you have a pacemaker? Y/N

PATIENT HISTORY

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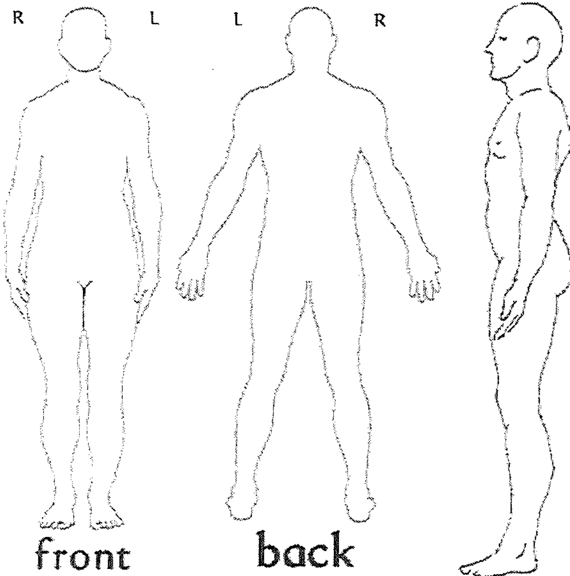
Patient Name________________________________ DOB: ____/_____/________

Date: ____/_____/________



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: ____

Signature:____

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Patient Name________________________________ DOB: ____/_____/________

Date: ____/_____/________

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 ☐ 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

Signature:____