Welcome to Anderson Chiropractic & Wellness Center

About You

Date:

Patient Name ______________ Last ______________ First ______________ M.I.

Male ☐ Female ☐ I would prefer to be called: ______________

Birthdate ______________ Age ______________ SS# ____ - ____ - ____

Street Address ______________ Apartment ______________

City ______________ State ______________ Zip Code ______________

Home Phone ______________ Work Phone ______________ Mobile ______________

Email Address ______________

Occupation ______________

Employer ______________ How Long? ______________

Employer Address ______________

City ______________ State ______________ Zip Code ______________

Status: Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Spouse's Name ______________ Number of children? ______________

Who may we thank for your referral? ______________ PCP ______________

Have you been to a chiropractor in the past? ☐ Yes ☐ No Name

Your Health History

Date of last:

Physical Exam ______________ X-Ray ______________

Spinal Exam ______________ MRI, CT or Bone Scan ______________

Are you taking any of the following medications? ☐ Nerve pills ☐ Pain Killers (including aspirin) ☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other (s) ______________

Place a mark on "Yes" or "No" to indicate if you've had any of the following:

Condition		Condition		Condition	
AIDS/HIV	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Other Headaches	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Muscular Dystrophy	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Digestive Disorder	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Numbness	☐ Yes ☐ No	Other	
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	______________	
Epilepsy	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	______________	
Fractures	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No		

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day ______________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week ______________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ______________
☐ Heavy	☐ Heavy Labor	☐ High Stress	Reason ______________

Are you pregnant? ☐ Yes ☐ No Due Date ______________

Please describe any injuries or surgeries you have had:

____

____

Your Concerns

What is your major complaint or concern? ______________________________

____

When did your symptoms appear? ______________________________

Are your symptoms ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other ______________

Other doctor(s) that treated you for this condition:

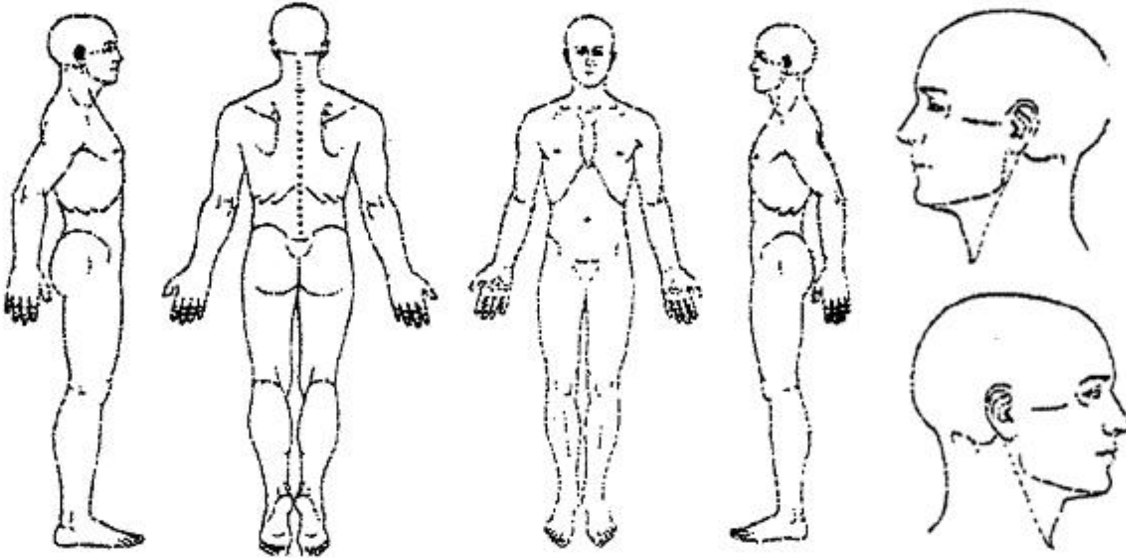
Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) ______________

Type of pain:

☐ **S**harp ☐ **D**ull ☐ **Th**robbing ☐ **A**ching ☐ **Sh**ooting

☐ **B**urning ☐ **N**umbness ☐ **T**ingling ☐ **St**iffness ☐ **O**ther

Place appropriate highlighted letters to mark the areas of discomfort



How often do you have this pain? ☐ +75% constant ☐ 50-75% Frequent ☐ 25-50% Occasional ☐ <25% Intermit

Does it interfere with Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Who else have you seen for this problem? ______________________________

Other comments or concerns regarding your condition:

____

Name of party responsible for payment Phone

Do you have health insurance? Name of company

*If an auto accident, please provide:

Insurance Company Name Contact Person

Phone: Claim #

Patient Signature: ______________________________ ______________

If patient is under 18:

Guardian Signature ______________________________ Date ______________