Anderson Chiropractic Case History

Patient Name____ Date______________
First MI Last

Address______________________________ City________________ State_______ Zip________

Phone #___________________________ Cellular phone carrier (for text reminders)______________

Email address ____

SSN________________ Birth date______________ Age______ ☐ Male ☐ Female

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Legally separated ☐

How did you hear about us? Internet ☐ Facebook/Instagram ☐ Insurance ☐ Other ☐ ______________

Employer______________________________ Occupation______________________________

Emergency contact________________________ Relationship____________ Phone____________

Reason for this visit____

Have you had this or similar conditions in the past? No ☐ Yes ☐

When did you first notice symptoms?____

Current symptoms are a result of: Work ☐ Sports ☐ Auto ☐ Injury/accident ☐ Chronic ☐ Other ☐ ____________

Is this condition: Improving ☐ Worsening ☐ Constant ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐

Which activities are difficult to perform? Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other ☐ ________

Have you seen anyone else for this condition? No ☐ Yes ☐ Who?______________________________

Have you been treated by a Chiropractor? No ☐ Yes ☐ Who?____________________ When?__________

Diagnosis?________________Treatment given? Chiro care ☐ Medication ☐ Surgery ☐ Other ☐ __________

List surgical operations and dates____

Do you use tobacco? No ☐ Yes ☐ How much?__________ Alcohol? No ☐ Yes ☐ How much?__________

Do you use controlled substances? No ☐ Yes ☐ How much?__________

Exercise? No ☐ Yes ☐ How often?__________ Are you pregnant? No ☐ Yes ☐ How far along?__________

Do you have, or have you had, any of the following?

☐ AIDS/HIV	☐ Emphysema	☐ Kidney problems	☐ Prostate trouble
☐ Anemia	☐ Epilepsy	☐ Mental illness	☐ Prosthesis/artificial bone/joint
☐ Appendicitis	☐ Fractures	☐ Migraine headaches	☐ Rheumatoid arthritis
☐ Arthritis	☐ Gout	☐ Multiple Sclerosis	☐ Scoliosis
☐ Back/neck surgery	☐ Heart attack	☐ Osteoporosis	☐ Seizures/fainting
☐ Cancer	☐ Heart disease	☐ Pacemaker	☐ Stroke
☐ Chickenpox/Shingles	☐ Hepatitis	☐ Parkinson's disease	☐ Tumors/growths
☐ Congenital heart defect	☐ Hernia	☐ Pinched nerve	☐ Ulcer/Colitis
☐ Diabetes	☐ Herniated disc	☐ Polio	☐ Vertigo
☐ Digestive issues	☐ High blood pressure		

------------------------------------- Please see other side -------------------------------------

Please check all that currently apply to you:

Pain or numbness in:

☐ Arms	☐ Recent weight change	☐ Sciatica	☐ Increase in thirst
☐ Back	☐ Fever	☐ Swelling of feet/ankles/hands	☐ Heat/cold intolerance
☐ Elbows	☐ Headaches	☐ Leg cramps	☐ Skin rash
☐ Feet	☐ Light headed/dizzy	☐ Joint pain	☐ Cold extremities
☐ Hands	☐ Jaw pain	☐ Joint stiffness/swelling	☐ Nausea/vomiting
☐ Hips	☐ Weakness	☐ Pain between shoulders	☐ Burning/painful urination
☐ Knees	☐ Chest pain/angina	☐ Vision problems	☐ Night pain
☐ Legs	☐ Heart palpitations	☐ Sinus problems	☐ Ringing in the ears
☐ Shoulders			
☐ Tailbone			
☐ Other______________			

List major concerns and rate the intensity of the pain on a scale of 0 (no pain) to 10 (severe pain):

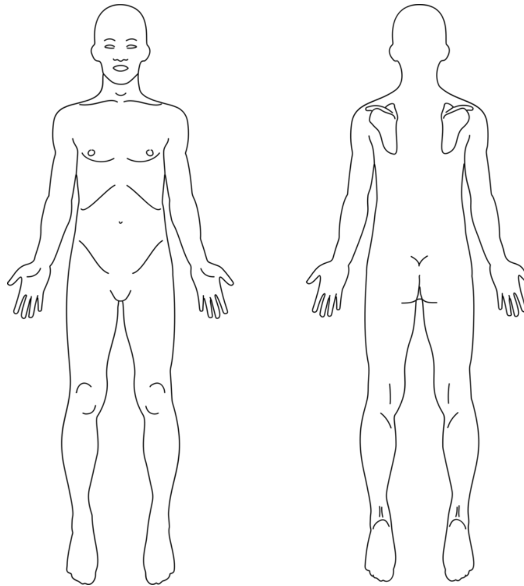
Primary concern ____ 0 1 2 3 4 5 6 7 8 9 10

Secondary concern ______________________________________ 0 1 2 3 4 5 6 7 8 9 10

Other concern ____ 0 1 2 3 4 5 6 7 8 9 10

Please mark the area(s) and type of pain/sensation you are feeling on the diagram below:

Numbness............... N
Pain............................ P
Tingling...................... T
Ache........................... A
Stiffness.................... S



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 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