Anderson Chiropractic

Charles M. Anderson, D.C.

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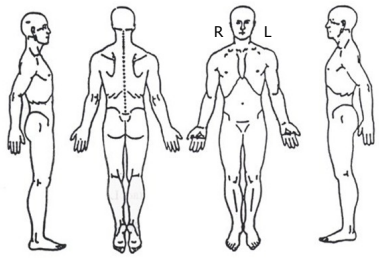
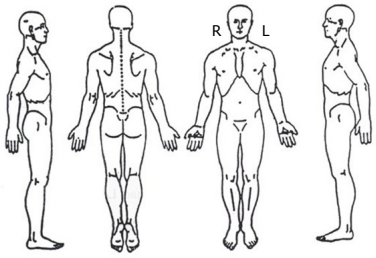
CONFIDENTIAL HEALTH INFORMATION
UPDATED HEALTH HISTORY

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

Name **Date**

Current Health Condition Describe your condition and the reasons your are seeking treatment.

Primary Complaint The primary symptom that prompted me to seek care today is: _____ _____ _____	**Secondary Complaint** The secondary symptom that prompted me to seek care today is: _____ _____ _____
Check all that apply ◯ Result of accident or injury: ◯ Work ◯ Auto ◯ Other ◯ A worsening long-term problem ◯ An interest in wellness	**Check all that apply** ◯ Result of accident or injury: ◯ Work ◯ Auto ◯ Other ◯ A worsening long-term problem ◯ An interest in wellness
Onset When did your symptoms start? _____	**Onset** When did your symptoms start? _____
Intensity How extreme are your symptoms? 0 1 2 3 4 5 6 7 8 9 10 Mild Mod Severe	**Intensity** How extreme are your symptoms? 0 1 2 3 4 5 6 7 8 9 10 Mild Mod Severe
Duration How often do you experience this? ◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent	**Duration** How often do you experience this? ◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent
Quality of Symptoms ◯ Numbness ◯ Tingling ◯ Stiffness ◯ Dull ache ◯ Cramping ◯ Nagging ◯ Sharp ◯ Throbbing ◯ Stabbing ◯ Burning ◯ Shooting ◯ Other	**Quality of Symptoms** ◯ Numbness ◯ Tingling ◯ Stiffness ◯ Dull ache ◯ Cramping ◯ Nagging ◯ Sharp ◯ Throbbing ◯ Stabbing ◯ Burning ◯ Shooting ◯ Other
Location Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.	**Location** Where does it hurt? Circle the area(s) on the illustration. "O" for current condition, "X" for conditions experienced in the past.
	
Radiation Where does your pain radiate or shoot to? _____	**Radiation** Where does your pain radiate or shoot to? _____
Aggravating or Relieving Factors Makes it worse: _____ Makes it better: _____	**Aggravating or Relieving Factors** Makes it worse: _____ Makes it better: _____
Prior Interventions What have you done for relief? ◯ Ice ◯ Heat ◯ Homeopathic Remedies ◯ Over-the-counter drugs ◯ Prescription medication ◯ Acupuncture ◯ Massage ◯ Chiropractic ◯ Physical therapy ◯ Surgery ◯ Other _____	**Prior Interventions** What have you done for relief? ◯ Ice ◯ Heat ◯ Homeopathic Remedies ◯ Over-the-counter drugs ◯ Prescription medication ◯ Acupuncture ◯ Massage ◯ Chiropractic ◯ Physical therapy ◯ Surgery ◯ Other _____

_____ _____
Signature Date

Activities of Daily Living What kind of negative effect does your condition have on your ability to function in the following situations? **0 = No effect, 1 = Mild, 2 = Moderate, 3 = Severe**

Sitting 0 1 2 3	Climbing Stairs 0 1 2 3	Using a computer 0 1 2 3
Standing 0 1 2 3	Concentrating 0 1 2 3	Rising out of a chair 0 1 2 3
Walking 0 1 2 3	Showering/bathing 0 1 2 3	Getting into/out of a car 0 1 2 3
Lying down 0 1 2 3	Getting dressed 0 1 2 3	Driving 0 1 2 3
Bending over 0 1 2 3	Exercising 0 1 2 3	Grocery shopping 0 1 2 3
Lifting objects 0 1 2 3	Getting to sleep 0 1 2 3	Household chores 0 1 2 3
Reaching overhead 0 1 2 3	Staying asleep 0 1 2 3	Yard work 0 1 2 3
Looking over shoulder 0 1 2 3	Love life 0 1 2 3	Caring for family 0 1 2 3

Review of systems Identify any changes since your most recent visit.

Worse	Same	Better		Such as...
○	○	○	**Musculoskeletal System**	osteoporosis, arthritis, neck pain, back problems, poor posture
○	○	○	**Neurological System**	anxiety, depression, headache, dizziness, pins and needles, numbness
○	○	○	**Cardiovascular System**	high/low blood pressure, high cholesterol, angina, etc.
○	○	○	**Respiratory System**	asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia
○	○	○	**Digestive System**	anorexia, bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea
○	○	○	**Sensory System**	blurred vision, ringing in ears, hearing loss, chronic ear infection
○	○	○	**Skin System**	skin cancer, psoriasis, eczema, acne, hair loss, rash
○	○	○	**Endocrine System**	thyroid issues, immune disorders, hypoglycemia, frequent infection
○	○	○	**Genitourinary System**	kidney stones, infertility, bedwetting, prostate issues, PMS symptoms
○	○	○	**Constitutional System**	fainting, low libido, poor appetite, fatigue, weakness, sudden weight gain/loss

Social History	*Daily*	*Weekly*	*How much?*
Alcohol use	○	○	_____
Coffee use	○	○	_____
Tobacco use	○	○	_____
Water intake	○	○	_____
Exercise	○	○	_____
Job stress	○	○	_____
Recreational drugs	○	○	_____

Medications and Supplements
List all prescriptions, over the counter drugs, natural supplements, enzymes, vitamins and minerals that you are currently taking.

_____
_____
_____
_____
_____

Acknowledgements To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials

_____ I instruct Dr. Anderson to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____ _____ _____
Patient's Name Signature Date

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Financial Policy

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

Initial an option and write the corresponding letter in the blank below.

Private pay, no insurance:

A _____ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed.

Private pay, patient filing own claims:

B _____ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered. As allowed by Oregon state law, I am requesting a "Time of Service Discount" when I pay for my services on the same day that services are performed. I am requesting a "Super Bill" be provided to me which includes the diagnosis so that I can submit a claim to my insurance company.

Health insurance:

C _____ I would like Anderson Chiropractic to bill my insurance. I understand that I am responsible for the costs of treatment, should my insurance company deny coverage for the claim submitted on my behalf. I acknowledge that it is my responsibility to find out whether my insurance covers all services rendered. I understand that if I let the office know which services are not covered, I will be eligible to receive the "Time of Service" discount for those services. I understand that I will be required to pay all co-pays or co-insurance percentages as stated in my insurance plan contract.

By my signature, I request option _____ as the method by which I will pay for my services performed in this clinic.

_____	_____	_____
Patient's Name	Signature	Date

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