Dr. Mandi Anderson, D.C.
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Welcome to Our Office!

CHIROPRACTIC CASE HISTORY/PATIENT INFORMATION:

Date:_____ Patient #_____ **Doctor: Dr. Mandi Anderson, D.C.**

Name:_____ Social Security #: _____ Gender: Male / Female

Home Phone: (___)_____ Cell Phone: (___)_____ E-mail Address:_____

Address:_____ City/State/Zip:_____

Birth Date:___/____/____ Age:_____ Marital Status (circle): ***Married Single Widowed Divorced Separated Partnered***

Occupation/School:_____Employer:_____Office Phone #:(____)_____

Employer's/School Address:_____

Spouse's Name:_____ Spouse's SS#_____

Spouse's Birth Date:___/____/___ Employer:_____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation: _____

Address: _____City/State/Zip _____

Home Phone: (___)_____ Cell Phone: (___)_____

INSURANCE INFORMATION:

Who is responsible for this accout?_____

_____Cash Pay _____Insurance Pay Insurance Name:_____

Whom May We Thank for Referring You?

_____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. **Our policy requires payment in full of all services rendered at the time of visit, unless other arrangements have been made with the doctor**. I authorize the doctor to perform any necessary services needed during the diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I have read and agree to the above statements.

Patient Signature: _____ Date:_____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: (Purpose of this appointment):_____

Date symptoms appeared or accident happened:_____ Is this due to: Auto____ Work____ Other_____

Is this condition getting progressively worse? Yes_____ No_____ Unknown_____

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

Type of pain: ___Burning ___Tingling ___Cramps ___Stiffness ___Aching ___Swelling ___Shooting ___Sharp ___Dull ___Throbbing ___Numbness ___Other: Explain_____

Have you ever had the same or similar condition? Yes / No

If yes, please describe: _____

How often do you have this pain?_____ Is it constant or come and go?_____

Days lost from work:_____ Does the pain interfere with your ___Work ___Sleep ___Daily Routine

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__AIDS/HIV	__Chicken Pox	__High Cholesterol	__Parkinson's	__Tonsillitis
__Alcoholism	__Diabetes	__Hypertension	__Pinched Nerve	__Tuberculosis
__Anemia	__Emphysema	__Kidney Disease	__Pneumonia	__Tumors/Growths
__Anorexia	__Epilepsy	__Liver Disease	__Polio	__Typhoid Fever
__Arthritis	__Fractures	__Measles	__Prostate Problem	__Ulcers
__Asthma	__Glaucoma	__Migraines	__Prosthesis	__Vaginal Infections
__Bleeding Disorder	__Goiter	__Miscarriage	__Psychiatric Care	__Venereal Disease
__Bronchitis	__Gonorrhea	__Mononucleosis	__Rheumatic Fever	__Whooping Cough
__Breast Lump	__Gout	__Multiple Sclerosis	__Scarlet Fever	__Other_____
__Bulimia	__Heart Disease	__Mumps	__Stroke	_____
__Cancer	__Hepatitis	__Osteoporosis	__Suicide Attempt	_____
__Cataracts	__Herniated Disc	__Pacemaker	__Thyroid Problems	

Please list/describe any major illnesses, injuries, falls, auto accidents or surgeries:_____

_____

Have you been treated for any health condition by a physician in the last year? Yes / No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

_____

Do you have any allergies to anything (including medications)? Yes / No

If yes, describe:_____

SOCIAL HISTORY:

Do you drink alcoholic beverages?_____ If so, how much per week?_____
Do you use any tobacco products?_____ If so, what_____
Do you smoke?____ If so, packs per day: _____
Do you take vitamin supplements?_____ If so, please list:_____
_____
Do you consume caffeine?____ If so, how much per day:_____
Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
What are your hobbies?_____

How many hours a day (at home or at your job) do you spend: lifting_____ sitting_____ bending_____ on computer_____

FAMILY HISTORY:

Parents:
Father: Living___ Deceased____ Current age(**if still living**):_____ Cause of death & age at death if deceased: _____

Mother: Living___ Deceased____ Current age(**if still living**):_____ Cause of death & age at death if deceased:_____

FAMILY DISEASES (check if applicable and indicate what family member is affected: **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis____	Cancer ____	Mental Illness ____
Diabetes ____	Asthma ____	Heart Disease ____
Stroke ____	Kidney Disease____	Lung Disease ____
Arthritis ____	Liver Disease ____	

Other _____

INSURANCE COVERAGE:

Please check any and all insurance coverage that may be applicable in this case**:**
____Major Medical ____Worker's Compensation ____Medicaid ___Medicare _____Auto Accident ____Medical Savings Account & Flex Plans ____Other

Name of Primary Insurance Company:_____Group #_____

Name of Secondary Insurance Company (if any):_____

When Doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes / No

Family Doctor: _____ Address:_____

Last Doctor Visit:_____ Phone: (___)_____

Have you seen them for your current problem?:_____

Is there anything else you would like to discuss that was not previously mentioned on this form? Please list any other health problems you have, no matter how insignificant they may seem_____
_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

_____

ACTIVITIES OF DAILY LIVING

Patient Name:_____ Date: _____

Check the appropriate space for the activities, which you have **PAIN** of **DIFFICULTY** with:

	Always	Sometimes	Never
1. Bending/Twisting/Turning	_____	_____	_____
2. Dressing the upper body	_____	_____	_____
3. Dressing the lower body	_____	_____	_____
4. Grooming/Bathing	_____	_____	_____
5. Going to the bathroom	_____	_____	_____
6. Meal preparation/clean-up	_____	_____	_____
7. Dusting, sweeping, cleaning	_____	_____	_____
8. Vacuuming	_____	_____	_____
9. Doing Laundry	_____	_____	_____
10. Needlework/Knitting/Hand Sewing	_____	_____	_____
11. Driving/riding in a car	_____	_____	_____
12. Getting in and out of car	_____	_____	_____
13. Climbing stairs	_____	_____	_____
14. Sitting	_____	_____	_____
15. Walking	_____	_____	_____
16. Running	_____	_____	_____
17. Recreational Activities_____	_____	_____	_____
18. Work Habits_____	_____	_____	_____
19. Yardwork_____	_____	_____	_____
20. Typing/Computer work	_____	_____	_____
21. Reading	_____	_____	_____
22. Shopping	_____	_____	_____
23. Carrying Groceries	_____	_____	_____
24. Sleeping	_____	_____	_____
25. Ironing	_____	_____	_____
26. Taking care of baby/child	_____	_____	_____
27. Other_____	_____	_____	_____
28. Other_____	_____	_____	_____