ANDERSON CHIROPRACTIC
Corey R. Anderson D.C.

Name: _____ DOB: _____ __ Male __ Female
Date: _____ Email Address: _____

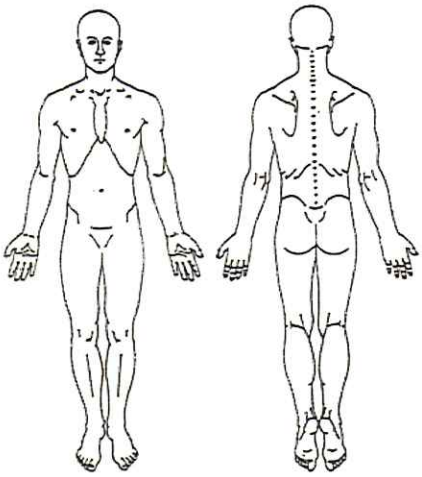
Occupation: _____
Employer: _____
What Is The Best Phone Number To Call For Appointment Reminders? _____
Who Referred You To Our Office? _____

(Females) Are You Pregnant?
__ Yes __ No __ Not Applicable

Have You Ever Received Chiropractic Care?
__ Yes __ No
If Yes, When? _____ What Is The Name Of The Most Recent Chiropractor? _____

What Brings You Into The Office Today/Primary Complaint? _____
_____
_____

Please Mark On The Figures Below Areas Of Pain/Symptoms:



Please Rate Your Pain On The VAS Pain Scale From 0-10 Where 0 Is No Pain And 10 Is The Worst Pain Imaginable:
0 1 2 3 4 5 6 7 8 9 10

When Did This Condition **Begin**? _____
What Caused This Condition Or **How Did It Happen**? _____
_____

What Have You Tried To **Correct/Help** This Condition? Examples-Medication, Other Doctors, Stretching Etc. _____

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This Condition Is:
__ Getting Better __ Getting Worse __ Remaining The Same

What Makes This Condition **Worse**? What Are You Having Problems Doing? Examples-Bending, Sleeping, Standing Etc. _____

What Makes This Condition **Better**? Examples-Ice, Heat, Chiropractic Adjustments Etc. _____
_____

Does The Pain **Travel Or Radiate**? If Yes, Where Does It RadiateToo? _____

Is the Pain Worse At A Certain **Time Of Day**? Examples-Morning, Afternoon, Night, Etc. _____
_____

Are You Being Treated For Any Other Health Condition(s)?
__ Yes __ No
If Yes, Please Explain: _____
_____

Please List All Medications You Are Taking (Include Medication Name And Reason For Taking)-Or Provide The Staff With A List: _____
_____
_____
_____

Have You Ever Had Cancer?
__ Yes __ No
If Yes, Please Explain-When And What Type: _____

Have You Ever Had A Stroke?
__ Yes __ No
If Yes, When Was It? _____

Do You Have Any Joint Replacements?
__ Yes __ No
If Yes, Which Joints? _____

Have You Had Any Spinal Surgeries?
__ Yes __ No
If Yes, Which Areas? _____

Please List All Surgeries You Have Had (Include Date And Type Of Surgery): _____
_____
_____
_____

Please List Any Previous Injuries/Traumas/Accidents Or Falls (Include Date And What Happened): _____
_____
_____

Have You Ever Broken Any Bones?
__ Yes __ No
If Yes, Which Bones? _____

Family Health History.
Do You Have A Family History Of (Please Indicate All That Apply)?
__ Cancer
__ Strokes/TIA's
__ Headaches/Migraines
__ Cardiac Disease/Heart Attack
__ Neurological Diseases
__ Adopted/Unknown
__ Cardiac Disease Below Age 40
__ Psychiatric Disease
__ Diabetes
__ Other _____

There Are Six Kinds Of Disturbances That Can Affect The Human Body. These Are The Following: GLANDULAR, ELIMINATIVE, NERVOUS, DIGESTIVE, MUSCULAR AND CIRCULATORY. All Dis-Eased Conditions, Aches & Pains And Other Discomforts Experienced By The Body Can Be Attributed To One Or More Of The Above Disturbances To The Body's 6 Systems Or "ZONES". Please Check All That Apply Below:

Zone 1 Glandular
__ Memory Loss
__ Anxiety/Depression
__ Skin Problem
__ Problems With Hair
__ Thyroid Problems/Low Energy
__ Low Immunity
__ Problems With Adrenals
__ Problems Sleeping/Relaxing
__ Menstrual Irregularity
__ Erectile Dysfunction/Fertility Issues
__ Feeling Stressed/Irritated/Short Tempered
__ Inability To Concentrate/Feel Foggy

Zone 2 Eliminative
__ Sinus Problems
__ Problems With Nasal Passages/Mucus
__ Throat Problems
__ Problems With Lungs/Bronchial Tubes/Coughing
__ Problems With Kidneys
__ Problems With Lymphatics
__ Bladder/Urinating Problems
__ Intestines/Colon/Bowel Movement Problems
__ Bronchitis/Pneumonia
__ Bloating

Zone 3 Nervous
__ Problems With Eyes
__ Problems With Ears/Other Sense Organs
__ Dizziness/Balance Issues
__ Problems Sleeping/Relaxing
__ Digestive Problems
__ Problems With Emotions
__ Nervousness/Tension
__ Numbness/Tingling
__ Headaches

Zone 4 Digestive
__ Abnormal Appetite
__ Decreased Taste/Foods Upsetting You
__ Acid Reflux/Heartburn/Indigestion
__ Problems With Liver
__ Gallbladder Problems
__ Stomach Problems
__ Problems With Pancreas
__ Intestinal Problems/Constipation/Loose Stools
__ Weight Gain/Problems Maintaining Weight
__ Problems Digesting Foods

Zone 5 Muscular

__ Neck Pain
__ Shoulder Pain
__ Pain In Arms/Hands
__ Upper/Middle/Lower Back Pain
__ Problems With Joints/Ligaments/Tendons
__ Pain In Chest/Abdomen/Muscles
__ Problems With Dizzines/Balance
__ Generalized Muscle Weakness
__ Foot Pain
__ Disc Problems
__ Muscle Pain/Spasms/Tightness
__ Leg/Lower Extremity Problems/Problems Walking/Tiring Easily
__ Problems With Flexibility/General Movement/Range Of Motion

Zone 6 Circulatory

__ Thyroid Gland Problems
__ Problems With Blood Pressure
__ Headaches/Migraines
__ Cold Hands/Feet
__ Heart Problems
__ Poor Circulation
__ Problems With Walking/Tiring Easily
__ Generalized Body Weakness/Aches/Pains

Informed Consent

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by Dr. Corey R Anderson and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

__ I have read and understand the above/Please Initial

HIPAA Consent

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund-raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

__ I have read and understand the above/Please Initial

Signature of Patient or Representative (If Minor Or Handicapped)
Signature: _____
Date: _____

Witness To Patients' Signature
Signature: _____
Date: _____