

ANDERSON SPECIFIC CHIROPRACTIC
1099 MERCHANTS DRIVE, SUITE B, DALLAS, GEORGIA 30132
PHONE: 770-443-4225 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonspecific.com

INFORMATION

Name: _____ DOB: _____ Date: _____

Hm Phn:() _____ Wk Phn:() _____ Cell Phn:() _____

Address: _____

City: _____ State: _____ Zip: _____ SS#: _____

Email: _____

Your Occupation: _____ Employer: _____

Marital Status: S M D W Spouse's Name: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Spouse's Work Phone:() _____ Nearest Friend or Relative: _____

Insured's Name: _____ Insured's DOB: _____ Insured's SS#: _____

Insured's Address: _____

Number of Children and Ages: _____ Have You Ever Received Chiropractic Care? _____

Sleeping Posture: Side Stomach Back (circle all that apply) Date of onset/accident: _____

Description of Accident/Injury/Onset: _____

Please tell us your condition during and after the accident /onset: _____

Who may we thank for referring you to our clinic? _____

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Present major complaint: _____ Date symptom began: _____

Other Symptoms:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Pins & needles in arms/hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hernia | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Inability to control urine |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Difficult breathing | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Prostate trouble |
| <input type="checkbox"/> Lights bothers eyes | <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Feet cold | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hands cold | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Deafness | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Earaches | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of the ankle | <input type="checkbox"/> Depression | <input type="checkbox"/> Excessive hunger |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Difficult digestion |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Numbness in fingers |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Neck pain | <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Numbness in toes |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Back pain | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Nasal drainage | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Belching or gas |
| <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Pain over stomach | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Painful tailbone | <input type="checkbox"/> Hardening of the arteries | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Faulty posture | <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney infection/stones | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Pins & needles in leg/feet | <input type="checkbox"/> Swollen joints |

ANDERSON SPECIFIC CHIROPRACTIC

1099 MERCHANTS DRIVE, SUITE B, DALLAS, GEORGIA 30132

PHONE: 770-443-4225 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonspecific.com

LOSS OF WELLNESS

Let's begin when you first damaged your nerve system, lost your wellness, and began your journey to ill health.

Growth and Development

YES NO

- Accidents?
 Were you taught to care for your spine?
 Did you play contact sports?
 Childhood sicknesses?
 Did you have Traumas? What? When?

Current Health Habits

YES NO

- Do you smoke?
 Do you drink any alcohol?
 Have you been in accidents?
 Physical stress/Mental Stress?
 Prescriptions?
 Over-the-counter drugs?

Other health concerns: _____

Have you ever been under drug and medical care? _____ Please describe: _____

What prescriptions and over-the-counter medications are you taking? _____

How long have you been taking these medications? _____

Have you had surgery? _____ What type? _____ When? _____

What side effects have you experienced from drugs and surgery? _____

Is there a family history of: Heart disease Arthritis Cancer Diabetes Other _____

Father's side: _____

Mother's side: _____

For our female patients, is there any possibility you are or may be pregnant? ___Yes ___No

Date of LMP (last period): _____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

ANDERSON SPECIFIC CHIROPRACTIC
1099 MERCHANTS DRIVE, SUITE B, DALLAS, GEORGIA 30132
PHONE: 770-443-4225 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonspecific.com

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra of the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements
(Print Name)

ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance company to pay by check payable to and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. I understand that I am fully responsible for the mutually agreed upon health fee between this clinic and myself. A photocopy of this assignment shall be considered as effective and valid as the original.

(Signature)

(Date)

RELEASE OF INFORMATION: In accordance with HIPPA regulations, I authorize this clinic to release any information necessary to process this claim.

(Signature)

(Date)