Anderson
INTEGRATED HEALTH CENTER

Patient Information

Today's Date: ____________________

Patient Name: ____

Address: ____

____

City State Zip

Sex: ☐ **Male** ☐ **Female** **Age:** _____ **Birth Date:** ____/_____/_____

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

Phone #: ____

Email: ____

Occupation: ____

Employer Name: ____

Employer phone number: ______-_________-_________________

Employer Address ____

Spouses Name: ____

Whom may we thank for referring you? ____________________________

IN CASE OF AN EMERGENCY, CONTACT:

Name: ____________________ **Relationship:** __________________

Phone Number: ____

Insurance

Who is responsible for this account? ___________________________

Relationship to patient ____

Insurance Company ____

Phone # ____

Member # or Group I.D ____

Subscribers Name: ____

Birth Date: _____/_____/________ **SS #:** _____________________

Is patient covered by additional insurance? ________Y________N_____

Relationship to patient _______________________________________

Insurance Company: ____

Group # or Member I.D ____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _________________________________ and assign directly to Dr. _________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party:

____

Relationship ____________________ **Date:** ______________________

Reason for Needing Care

What is the reason for your visit or symptoms you are suffering from?

____

____

____

____

Accident Information

Is condition due to an accident? ☐ **Yes** ☐ **No** **Date:** ________________

Type of accident ☐ **Auto** ☐ **Work** ☐ **Home** ☐ **Other**

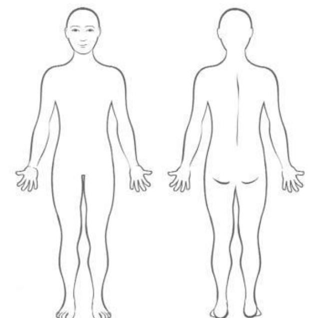
Was this accident reported? ☐ **Y** ☐ **N**

If yes, to whom? ____

Attorney Name (if applicable): __________________________________

Patient Condition

MARK THE DIAGRAM TO THE RIGHT WITH AN "X" WHEREVER YOU HAVE PAIN OR DISCOMFORT ON YOUR BODY



When did your symptoms appear? ______________ **Is this condition getting progressively worse?** ☐ **Yes** ☐ **No**

Mark an X on the picture where you continue to have pain, numbness, or tingling.

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

Type of pain: ☐ **Sharp** ☐ **Dull** ☐ **Throbbing** ☐ **Numbness** ☐ **Aching** ☐ **Shooting**

☐ **Burning** ☐ **Tingling** ☐ **Cramps** ☐ **Stiffness** ☐ **Swelling**

How often do you have this pain? ___________________________ **Is It consistent or does it come and go?** ____________________________

Does it interfere with your: ☐ **Work** ☐ **Sleep** ☐ **Daily** ☐ **Routine** ☐ **Recreation**

Activities or movements that are painful to perform: ☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lying down**

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition: ____________________

____

Date of Last: Physical Exam: ____________ Spinal X-Ray: ____________ Blood Test: ____________

Spinal Exam: ____________ Chest X-Ray: ____________ Urine Test: ____________

Dental X-Ray: ____________ MRI, CT-Scan, Bone Scan: ____________

Please mark "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Measles	☐ YES	☐ NO	Rheumatoid Arthritis	☐ YES	☐ NO
Alcoholism	☐ YES	☐ NO	Emphysema	☐ YES	☐ NO	Migraine Headaches	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Allergy Shots	☐ YES	☐ NO	Epilepsy	☐ YES	☐ NO	Miscarriage	☐ YES	☐ NO	Scarlet Fever	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Fractures	☐ YES	☐ NO	Mononucleosis	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Anorexia	☐ YES	☐ NO	Glaucoma	☐ YES	☐ NO	Multiple Sclerosis	☐ YES	☐ NO	Suicide Attempt	☐ YES	☐ NO
Appendicitis	☐ YES	☐ NO	Goiter	☐ YES	☐ NO	Mumps	☐ YES	☐ NO	Thyroid Problems	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	Gonorrhea	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO	Tonsillitis	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Gout	☐ YES	☐ NO	Pacemaker	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Bleeding Disorder	☐ YES	☐ NO	Heart Disease	☐ YES	☐ NO	Parkinson's Disease	☐ YES	☐ NO	Tumors, Growths	☐ YES	☐ NO
Breast Lump	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO	Pinched Nerve	☐ YES	☐ NO	Typhoid Fever	☐ YES	☐ NO
Bronchitis	☐ YES	☐ NO	Hernia	☐ YES	☐ NO	Pneumonia	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO
Bulimia	☐ YES	☐ NO	Herniated Disk	☐ YES	☐ NO	Polio	☐ YES	☐ NO	Vaginal Infections	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Herpes	☐ YES	☐ NO	Prostate Problems	☐ YES	☐ NO	Venereal Disease	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO	High cholesterol	☐ YES	☐ NO	Prosthesis	☐ YES	☐ NO	Whooping cough	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO	Other____________		
Chicken Pox	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO				____________		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day____________
☐ Alcohol — Drinks/Week____________
☐ Coffee/Caffeine — Cups/Day____________
☐ High Stress Level — Reason____________

Are you pregnant? ☐ Yes ☐ No Due Date____________

Injuries/Surgeries you have had — Description — Date

Falls ____________________

Head Injuries ____________________

Broken Bones ____________________

Dislocations ____________________

Surgeries

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
____________	____________	____________
____________	____________	____________
Pharmacy Name ____________	____________	____________
Pharmacy Phone ____________	____________	____________