

# Derik S Anderson, DC

## Patient Information

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_  
Age \_\_\_\_\_  
Marital Status S M D W # of children \_\_\_\_ Occupation \_\_\_\_\_  
Telephone (home) \_\_\_\_\_ Telephone (work) \_\_\_\_\_  
Telephone (cell) \_\_\_\_\_ DL# \_\_\_\_\_  
Email \_\_\_\_\_ Referred by \_\_\_\_\_

## SYMPTOMS (Please circle all that apply)

HEAD:	▲ lifting	Numbness of arm R/L	Cramps in feet R/L
Loss of	▲ standing	Numbness of hand	Swollen ankles R/L
▲ memory	▲ sitting	R/L	Swollen feet R/L
▲ hearing	▲ bending	Fingers go to sleep	GENERAL:
▲ balance	Arthritis	Hands cold	Nervousness
Light-headedness	ABDOMEN:	Swollen fingers R/L	Irritable
Dizziness	Nervous stomach	Sore joints R/L	Depressed
Fainting	Nausea	Arthritis	Fatigue
Light bothers eyes	Gas	CHEST:	Generally feel run-
Ringing in ears	Constipation	Shortness of breath	down
NECK:	Diarrhea	Pain around ribs	Loss of sleep
Stiff neck	SHOULDERS:	HIPS, LEGS & FEET:	Loss of weight
Grinding sounds	Can't raise arm above	Leg cramps	Weight gain
Arthritis	▲ shoulder level	Numbness of leg R/L	
BACK:	▲ over head	Numbness of feet R/L	
Pain is worse when:	ARMS & HANDS:	Feet cold	

### WOMEN ONLY:

Menstrual Pain Cramping Irregularity Date of last period? \_\_\_\_\_ Are you now pregnant? Y/N

Have you had X-Rays taken in the past three years? Yes No What area? \_\_\_\_\_

History and dates of previous surgeries, illnesses, or diseases \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Personal and/or family medical history \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Diet, Supplement, and Medication Diary

Please write down every thing that you have eaten and any supplements and medications during the previous 3 days. This will ensure that you receive the best care possible.

	<u>Today</u>	<u>Yesterday</u>	<u>Two days ago</u>
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Notes			

Please list all supplements and medications you are currently taking and their dosages:

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# D e r i k S A n d e r s o n , D C

## Office Policies

We are proud to offer the finest holistic health care. Success lies in the cooperation between you and the doctor. Your treatment program will reflect what is required to solve, in our best estimation, your health problems. Therefore, your understanding and compliance with the following office policies will help ensure that you obtain your health goal and the most out of your treatment.

## Appointments

An appointment is an agreement made between you and your doctor, and, as such, should be kept by both parties. If you feel you need a different appointment, please discuss it with us as soon as possible. There are circumstances that make it impossible to keep an appointment. For these rare occasions, the following policy applies:

## Cancellations

To reschedule an appointment without charge you must call the office 24 hours in advance. Otherwise, there will be a charge for the missed appointment that must be paid by the patient. Appointments must be rescheduled within three days of the originally scheduled appointment, to ensure maximum benefit from your therapy.

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## PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

\_\_\_\_\_, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) via email to the email that I have provided in this intake form packet or otherwise, written or electronically, to The Practice.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

D e r i k S A n d e r s o n , D C

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
  6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
  7. I authorize The Practice to communicate electronically with me via email, at the address provided in this patient intake packet or via another email address I have provided, either written or electronically.
  8. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
  9. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
- I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative  
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

\_\_\_\_\_  
Relationship

Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_