

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) _____ Medical Doctor _____
Email _____ Referred by _____

SYMPTOMS (Please circle all that apply)

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

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 _____

DERIK S ANDERSON, DC

Name _____

Date of injury/when symptoms first began, If applicable.

Please list your major health concerns, in order of importance:

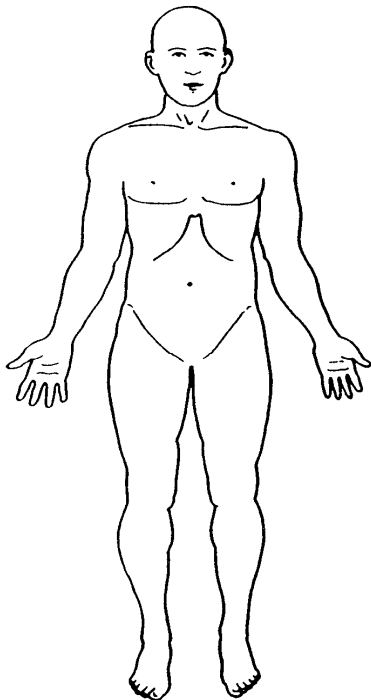
- | | | |
|----|--|--|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Area of Pain	Right/Left	No Pain	Mild	Moderate	Severe	C/I
	R/L	0 1 2 3 4 5 6 7 8 9 10				C/I
	R/L	0 1 2 3 4 5 6 7 8 9 10				C/I
	R/L	0 1 2 3 4 5 6 7 8 9 10				C/I
	R/L	0 1 2 3 4 5 6 7 8 9 10				C/I
	R/L	0 1 2 3 4 5 6 7 8 9 10				C/I

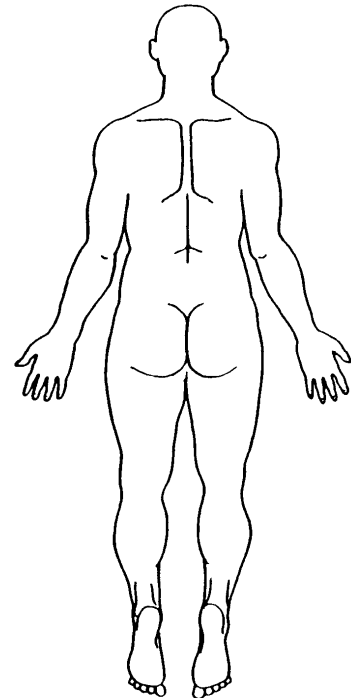
0=No Pain

10=Childbirth, Passing Kidney Stone

C=Constant I=Intermittent



Sharp and Stabbing = ++++
 Dull and Achy = VVVV
 Pins and Needles = 0000
 Numbness = IIII



DERIK S ANDERSON, DC

Diet, Supplement, and Medication Diary

Please write down every thing that you have consumed (food, beverage, etc) and any supplements and medications taken during the previous 3 days.

	<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:

DERIK S ANDERSON, DC

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.

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Derik Anderson and/or other licensed doctors of chiropractic who now or in the future work at the office listed on this form or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

HIPAA

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.

DERIK S ANDERSON, DC

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.
 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: _____