

**CHIRO NEW PATIENT FORMS – PLEASE FILL OUT AS COMPLETELY AS POSSIBLE**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_  
**Email Address:** \_\_\_\_\_ **SEX - M or F** **Marital Status** \_\_\_\_\_ **Spouse's Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_  
**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_  
 Have you ever received Chiropractic Care? (Circle One) **YES or NO** If yes, when? \_\_\_\_\_  
**Name of most recent Chiropractor:** \_\_\_\_\_  
**Social Security Number:** \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**CURRENT/PAST HEALTH HISTORY -- Please indicate if you have a history of any of the following:**

- Anticoagulant use
- Heart problems/high blood pressure/chest pain
- Bleeding problems
- Lung problems/shortness of breath
- Cancer
- Diabetes
- Osteoporosis/Osteopenia
- Stroke/TIA

**Previous Injuries or Trauma:** \_\_\_\_\_  
 Have you ever broken any bones? Which? \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**MEDICATIONS: (Please list all medications you are currently taking and why)**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SURGERIES: (Please list types of surgery and date performed)**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY**

Recreational activities: (hobbies, level of exercise, etc.) \_\_\_\_\_  
 Do you smoke? YES or NO If yes, how many packs/day? \_\_\_\_\_  
 Do you drink alcohol? If yes, how often? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**FAMILY HEALTH HISTORY -- Please indicate if anyone in your family has/had a history of any of the following:**

- |   |                    |
|---|--------------------|
| ___ Cardiac disease below age 40                  | If yes, who? _____ |
| ___ Heart problems/high blood pressure/chest pain | If yes, who? _____ |
| ___ Lung problems/shortness of breath             | If yes, who? _____ |
| ___ Cancer  | If yes, who? _____ |
| ___ Diabetes                                      | If yes, who? _____ |
| ___ Osteoporosis/Osteopenia                       | If yes, who? _____ |
| ___ Stroke/TIA                                    | If yes, who? _____ |
| ___ Adopted or Unknown Family History             |                    |

Is there anything else about your health that you would like us to know?  
\_\_\_\_\_

**ASSIGNMENT OF BENEFITS FOR DIRECT PAYMENT TO DOCTOR**

PLEASE READ THIS CAREFULLY

I hereby instruct and direct my insurance company to pay by check made payable and mailed directly to:

**Anderson Chiropractic  
1110 N Five Mile Rd  
Suite 200  
Boise, Idaho 83713**

for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy.

The payment will not exceed my indebtedness to the above mentioned assignee and **I agree to pay any balance of said professional services over and above this insurance payment.** I understand and agree that I am ultimately responsible for all fees including reasonable collection costs and services not covered by my insurance contract. It is my responsibility to obtain and understand my insurance benefits prior to receiving services. This assignment of benefits does not release me from the obligation to pay professional fees. A photocopy of this assignment of benefits shall be considered as effective and valid as the original.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Guardian

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**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 READ IT CAREFULLY.

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

**Use and Disclosures of Protected Health Information**

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

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your healthcare services.

**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 include 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. 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.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent for Chiropractic Treatment

**TO THE PATIENT:** *You have the right to be informed about your condition, the recommended chiropractic treatment and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision about whether or not to have the treatment.*

I request and consent to chiropractic treatment. The chiropractic treatment may include adjustments, other chiropractic procedures including various modes of physical therapy and diagnostic x-ray. The chiropractic treatment will be performed by a Chiropractic Doctor.

I will have the opportunity to discuss with the Chiropractor my diagnosis, the nature and purpose of my treatment, the risks and benefits of my chiropractic, the alternatives to my treatment and the risks and benefits of alternative treatment including no treatment at all.

I understand that there are some risks involved in chiropractic treatment including but not limited to **broken bones, dislocations, sprains or strains, increased symptoms and pain, temporary pain or discomfort, bruising, swelling, and no improvement in symptoms or pain.**

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical (neck) adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control the eye movements, and death.

I do not expect the doctor to be able to anticipate and explain all risks or complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

**I have read or have had read to me the above consent. I have also had the opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment within this office.**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please check the line next to the symptoms you currently have.

**PULMONARY/LUNG RELATED**

- Asthma/difficulty breathing
- COPD
- Emphysema
- Other \_\_\_\_\_
- None of the above

**CARDIOVASCULAR/HEART RELATED**

- Heart Surgeries
- Congestive Heart Failure
- Murmurs or valvular disease
- Heart Attack/MI
- Heart Disease/Problems
- Hypertension
- Pacemaker
- Angina/Chest Pain
- Irregular heartbeat
- Other \_\_\_\_\_
- None of the above

**NEUROLOGICAL/NERVE RELATED**

- Visual changes/loss of vision
- One sided weakness of face/body
- History of seizures
- Headaches
- One sided decreased feeling of face/body
- Memory loss
- Tremors
- Vertigo
- Loss of sense of smell
- Strokes/TIA
- Other \_\_\_\_\_
- None of the above

**ENDOCRINE/GLANDULAR/HORMONAL**

- Thyroid Disease
- Hormone replacement therapy
- Injectable steroid replacements
- Diabetes
- Other \_\_\_\_\_
- None of the above

**RENAL/KIDNEY RELATED**

- Renal calculi/stones
- Hematuria (blood in urine)
- Incontinence
- Bladder infections
- Difficulty urinating
- Kidney disease
- Dialysis
- Other \_\_\_\_\_
- None of the above

**GASTROENTEROLOGICAL/STOMACH RELATED**

- Nausea
- Difficulty swallowing
- Ulcerative disease
- Abdominal pain
- Hiatal hernia
- Constipation
- Pancreatic disease
- Irritable bowel/colitis
- Hepatitis or liver disease
- Bloody or black stools
- Vomiting blood
- Bowel incontinence
- Reflux/heartburn
- Other \_\_\_\_\_
- None of the above

**HEMATOLOGICAL/BLOOD RELATED**

- Anemia
- Regular Anti-Inflam med use
- HIV Positive
- Abnormal bleeding/bruising
- Sickle cell anemia
- Enlarged lymph nodes
- Hemophilia
- History of blood clots/DVT
- Anticoagulant therapy
- Regular aspirin use
- Other \_\_\_\_\_
- None of the above

**DERMATOLOGICAL/SKIN RELATED**

- Significant burns
- Significant rashes
- Skin Grafts
- Psoriatic disorders
- Other \_\_\_\_\_
- None of the above

**MUSCULOSKELETAL/BONE OR MUSCLE RELATED**

- Rheumatoid arthritis
- Gout
- Osteoarthritis
- Broken bones
- Spinal fractures
- Joint surgery
- Arthritis (unknown type)
- Scoliosis
- Metal implants
- Other \_\_\_\_\_
- None of the above

I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient or Guardian Signature \_\_\_\_\_

\_\_\_\_\_ Date

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

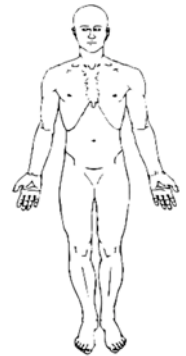
### PATIENT SYMPTOM FORM

(Please list each of your symptoms individually ie: headache, neck pain, tingling etc. Use additional pages if needed)

SYMPTOM # 1 \_\_\_\_\_

- On a scale of 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time when you are awake do you experience the above symptom at the above intensity? 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
- Did the symptom begin **SUDDENLY** or **GRADUALLY** (circle one)
- How did the symptom begin? \_\_\_\_\_
- Was the symptom a result of a motor vehicle collision? **YES** or **NO** (circle one)
  - If yes, did you have the symptom before the motor vehicle collision? **YES** or **NO** (circle one)
  - If yes, what was the intensity? On a scale of 0-10, with 10 being the worst, please circle the number that best describes the intensity most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What makes the symptom worse? (check all that apply)

Bending neck forward	Bending neck backward	Tilting head to left
Tilting head to right	Turning head to left	Turning head to right
Bending forward at waist	Bending backward at waist	Twisting left at waist
Twisting right at waist	Sitting	Standing
Getting up from sitting	Lifting	Any movement
Driving	Walking	Running
Nothing	Other	

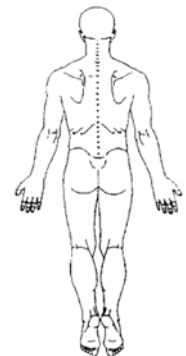


- What makes the symptom better? (check all that apply)

Ice	Heat	Exercise
Massage	Pain Medication	Muscle Relaxers
Nothing	Other	

- Describe the quality of your symptom. (check all that apply)

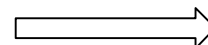
Sharp	Dull	Achy
Burning	Throbbing	Piercing
Stabbing	Deep	Nagging
Shooting	Stinging	Other



- Does the symptom radiate to another part of your body? **YES** or **NO** (circle one)
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (check one)

Morning	Afternoon	Evening	Night
---------	-----------	---------	-------

Please indicate on the diagrams to the right where your symptom is located



Is there anything else you would like the doctor to know about your symptom?

---

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

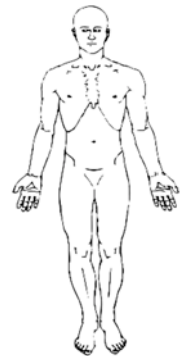
### PATIENT SYMPTOM FORM

(Please list each of your symptoms individually ie: headache, neck pain, tingling etc. Use additional pages if needed)

**SYMPTOM # 2** \_\_\_\_\_

- On a scale of 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time when you are awake do you experience the above symptom at the above intensity? 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
- Did the symptom begin **SUDDENLY** or **GRADUALLY** (circle one)
- How did the symptom begin? \_\_\_\_\_
- Was the symptom a result of a motor vehicle collision? **YES** or **NO** (circle one)
  - If yes, did you have the symptom before the motor vehicle collision? **YES** or **NO** (circle one)
  - If yes, what was the intensity? On a scale of 0-10, with 10 being the worst, please circle the number that best describes the intensity most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What makes the symptom worse? (check all that apply)

Bending neck forward	Bending neck backward	Tilting head to left
Tilting head to right	Turning head to left	Turning head to right
Bending forward at waist	Bending backward at waist	Twisting left at waist
Twisting right at waist	Sitting	Standing
Getting up from sitting	Lifting	Any movement
Driving	Walking	Running
Nothing	Other	

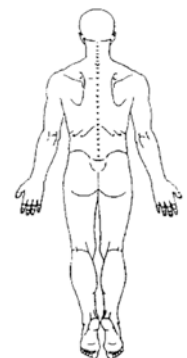


- What makes the symptom better? (check all that apply)

Ice	Heat	Exercise
Massage	Pain Medication	Muscle Relaxers
Nothing	Other	

- Describe the quality of your symptom. (check all that apply)

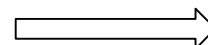
Sharp	Dull	Achy
Burning	Throbbing	Piercing
Stabbing	Deep	Nagging
Shooting	Stinging	Other



- Does the symptom radiate to another part of your body? **YES** or **NO** (circle one)
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (check one)

Morning	Afternoon	Evening	Night
---------	-----------	---------	-------

Please indicate on the diagrams to the right where your symptom is located



Is there anything else you would like the doctor to know about your symptom?

---

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

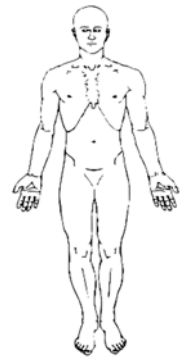
### PATIENT SYMPTOM FORM

(Please list each of your symptoms individually ie: headache, neck pain, tingling etc. Use additional pages if needed)

SYMPTOM # 3 \_\_\_\_\_

- On a scale of 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time when you are awake do you experience the above symptom at the above intensity? 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin? \_\_\_\_\_
- Did the symptom begin **SUDDENLY** or **GRADUALLY** (circle one)
- How did the symptom begin? \_\_\_\_\_
- Was the symptom a result of a motor vehicle collision? **YES** or **NO** (circle one)
  - If yes, did you have the symptom before the motor vehicle collision? **YES** or **NO** (circle one)
  - If yes, what was the intensity? On a scale of 0-10, with 10 being the worst, please circle the number that best describes the intensity most of the time. 0 1 2 3 4 5 6 7 8 9 10
- What makes the symptom worse? (check all that apply)

Bending neck forward	Bending neck backward	Tilting head to left
Tilting head to right	Turning head to left	Turning head to right
Bending forward at waist	Bending backward at waist	Twisting left at waist
Twisting right at waist	Sitting	Standing
Getting up from sitting	Lifting	Any movement
Driving	Walking	Running
Nothing	Other	

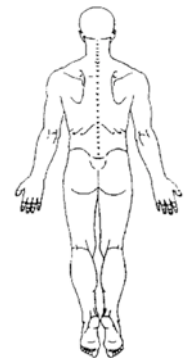


- What makes the symptom better? (check all that apply)

Ice	Heat	Exercise
Massage	Pain Medication	Muscle Relaxers
Nothing	Other	

- Describe the quality of your symptom. (check all that apply)

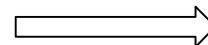
Sharp	Dull	Achy
Burning	Throbbing	Piercing
Stabbing	Deep	Nagging
Shooting	Stinging	Other



- Does the symptom radiate to another part of your body? **YES** or **NO** (circle one)
  - If yes, where does the symptom radiate? \_\_\_\_\_
- Is the symptom worse at certain times of the day or night? (check one)

Morning	Afternoon	Evening	Night
---------	-----------	---------	-------

Please indicate on the diagrams to the right where your symptom is located



Is there anything else you would like the doctor to know about your symptom?

---