Anderson Family Chiropractic, P.C.
4025 Automation Way, C2
Fort Collins, CO 80525
970.225.1006

PATIENT INTRODUCTORY INFORMATION

Name:____Date:___________

Street Address: ____

City: ___________________________________ State: _________ Zip Code: _____________

Home Phone: _________________ Work:________________ Cell:_________________

Birthdate: ____________________ M ______ F ______

Occupation: ____

Spouse/Parents Name:____

Emergency Contact: ______________________________ Phone:________________________

Who referred you to our office?____

PATIENT HISTORY

Have you had previous chiropractic care? ______________ DR.____________________________

CURRENT HEALTH

Chief Complaint : ____

Date of Onset:________________________ Is pain ☐sharp or ☐dull?

Current Medication:____

Purpose:____

Current Vitamins:____

Habits: ____

Current MD & Treatment:____

HEALTH HISTORY

Broken bones/Implants;____

Surgeries and dates:____

Hospitalizations:____

Accidents(auto/falls etc):____

FAMILY HISTORY

Past and present health problems

Mother:____

Father:____

Siblings:____

Are you experiencing any of the following:

☐ Nose Bleeds	☐ Allergies	☐ Nausea
☐ Sleeplessness	☐ Female issues	☐ Neck Pain
☐ Male issues	☐ Gallbladder problems	☐ Mid Back Pain
☐ Headaches	☐ Depression	☐ Low Back Pain
☐ Digestive problems	☐ Dizziness	☐ Joint Pain
☐ Fatigue	☐ Asthma	☐ Other: ________________

Welcome to Anderson Family Chiropractic

Dear Patients,

We are committed to providing you with both excellent healthcare and nutritional support.
Please read and initial the following policies regarding payments for the service and products you receive and Anderson Family Chiropractic.

I understand that payment in full for services and products is expected at the completion of each visit. _____ Initial

Mail order products must be paid for prior to shipping _____ Initial

Interest charges or fees may be assessed on an account that has a balance at the discretion of Anderson Family Chiropractic. _____ Initial

HOW WILL YOU BE PAYING TODAY?

- ☐ Cash
- ☐ Check
- ☐ Major Credit Card
- ☐ Care Credit (check our link on the web site or go to CareCredit.com)

DISCLAIMER REGARDING THE HEALTHSCAN AND BODYSCAN

The HealthScan and the Phazx BodyScan 2010 are used by Dr. Donald Anderson for educational purposes only. These techniques are not used to diagnose, prevent, or cure any health ailments. Dr. Anderson may give his interpretation of the Scan findings, however you the patient, with information provided in the HealthScan and BodyScan, are solely responsible for any protocols that you choose to implement after studying the findings.

_____Initial

I understand and accept the above policies and acknowledge that I am financially responsible for services rendered and products received. I also understand that I am financially responsible for any overdue charges or collection fees applied to my account.

Patient Signature____ Date:_____________
(Parent must sign for minor)

Staff Signature____ Date:_____________

Patient Name____ Today's Date__________________________

Help us understand your pain/discomfort: (Please check the number which closely describes your chief complaint(s) today)

1. Pain Intensity

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency of pain

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
No Pain	Occasional Pain 25% of day	Intermittent Pain 50% of day	Frequent Pain 75% of day	Constant Pain 100% of day

3. Personal Care (washing/dressing etc)

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
No Pain	Mild Pain No Restrictions	Moderate Pain Need to go slowly	Moderate Pain Need some assistance	Severe Pain Need 100% assistance

4. Travel (Driving/Riding etc)

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
No Pain On long trips	Mild Pain On long trips	Moderate Pain On long trips	Moderate Pain On short trips	Severe Pain On short trips

5. Work

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Can do usual work Plus extra work	Can do usual work No Extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can't do any activities

7. Sleeping

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
No Pain Any Distance	Increased Pain After 1 mile	Increased Pain After ½ mile	Increased Pain After ¼ mile	Increased Pain With all walking

10. Standing

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
No Pain After several hours	Increased Pain After several hours	Increased Pain After 1 hour	Increased Pain After half hour	Increased Pain With any standing

11. Appetite

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Does not affect appetite	Less of an appetite	No appetite	More hungry than normal	Overly hungry or strong food cravings

12. Mood

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Does not affect mood	Affects mood 25%	Affects mood 50%	Affects mood 75%	Affects mood constantly

13. Energy

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
Does not affect energy	25% less energy	50% less energy	75% less energy	No energy