**HEALTH HISTORY FORM**

**Personal Information**

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

Age: \_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_ Birth date : \_\_\_\_\_\_\_\_\_\_\_\_ Sex: □ M □ F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Please add me to your email list

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Health Concern**

□ If there are no current concerns and this assessment is to ensure optimum health, function and wellness tick this box

Health Concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) 1 2 3 4 5 6 7 8 9 10

Circle or describe it’s character: Sharp , dull, ache, burning, tingling, throbbing, spasm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you first notice it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happened? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often does it occur?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What relieves it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What aggravates it?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it radiate or cause problems somewhere else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any associated or related concerns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other professionals seen for this: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Treatment and results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recent tests done: □ Bloodwork □ Urine □ xRays

**Other Health Concerns**

Please note all other health concerns present or in the past. Please tick applicable boxes.

□ Allergies □ Arthritis □ Asthma □ Blood Pressure hi/lo

□ Blood Sugar hi/lo □ Bleeding Disorder □ Cancer □ Colds (frequent)

□ Diabetes □ Digestive Disorder □ Dizziness □ Fatigue

□ Fertility Challenges □ Headaches □ Heart Disease □ Lowered Resistance

□ Menstrual Pain □ Migraines □ Multiple Sclerosis □ Numbness/Tingling

□ Osteoporosis □ Pneumonia □ Pinched Nerve □ Prostate Problem

□ Parkinson’s Disease □ Seizures □ Stroke □ Thyroid Disorder

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**

For women: Are you pregnant? □ Yes □ No □ Unknown

**Physical Stresses**

Any significant injuries, falls or traumas during infancy or childhood? □ Yes □ No □ Unsure

If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any significant injuries, falls or traumas during adulthood? □ Yes □ No □ Unsure

If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any hospital visits? □ Yes □ No Have you had any surgeries, fractures, car accidents? □ Yes □ No

If yes please explain and list dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in prolonged postures? (ie: repetitive work, lifting, sitting, driving) □ Yes □ No

If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any hobbies that are physically strenuous or have repetitive movements? □ Yes □ No

If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your exercise level? □ Low □ Moderate □ Heavy □ 1-3x/wk □4-7x/week

What do you do for exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What position do you sleep in? □ Back □ Side □ Stomach For how many hours?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any fractured bones or dislocations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chemical Stresses**

Are you taking prescription or over-the-counter medications? □ Yes □ No

If yes please explain what you are taking & why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking supplements? □ Yes □ No

If yes please explain what you are taking and why:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? □ Yes □ No □ Quit If yes, how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? □ Yes □ No If yes, approximately how much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy with your diet? □ Yes □ No

Do you eat a specific diet? If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exposed to pollutants, strong smells, chemicals, aerosols? □ Yes □ No □ Occassionally

**4**

**Anderson Chiropractic Group Informed Consent**

In order for the Doctor of Chiropractic indicated below to make a determination on the suitability of my case for chiropractic care, I acknowledge and understand that I must complete a thorough chiropractic evaluation, which may include a diagnostic radiographic examination if clinically indicated. I do hereby request and consent to the performance of such an evaluation by the Chiropractor indicated below, or any party authorized to do so by that Chiropractor.

I have had the opportunity to discuss with the Doctor of Chiropractic indicated below, or with any party authorized to do so by that Chiropractor, about the nature and purpose of Chiropractic adjustments and other procedures. I understand that there are, however, some risks associated with Chiropractic care, as there are with any and all healthcare treatments. In healthcare, the matter of whether any treatment is appropriate or not is determined by looking at the level of risk and comparing this with the level of expected benefit.

I understand that in rare cases there have been incidents of injury to the vertebral artery during the course of care to the cervical spine by medical doctors, physiotherapist, and chiropractors. However, the proposed mechanism of this injury is reproduced by a wide variety of trivial neck movements such as coughing sneezing, turning your head to look out the back of a car, or having a shampoo at a hair salon. This injury is of concern because it may lead to stroke. The risk of stroke after a cervical adjustment is estimated to be approximately 1 in 1 million. To put this in perspective, studies that have assessed the risk from interventions a non-chiropractor commonly uses for the same complaints have found the following:

Risk of paralysis or stroke from surgeries or neck pain 15, 600 per 1 million

Risk of death from surgery for neck pain 6, 900 per 1 million

Risk of serious GI event from a NSAID (eg.Aspirin,ibuprofen) 1,000 per million

Risk of stroke following a chiropractic adjustment 1 per 1 million

To put this further into perspective, these studies estimate the risk of death before the age of 35 due to smoking cigarettes is 1677 per 1 million, and annual risk for being injured in a car accident is 13, 333 per 1 million.

Another complication that may arise following a spinal adjustment is a rib fracture, muscle strain, or ligament sprain. These complications are extremely remote and the Doctor of Chiropractic is trained to assess your spine and adjust in ways that significantly diminish the risk of this occurring.

I have read and understood the risks inherent in undergoing chiropractic care, although, I do not expect the Doctor to be able to anticipate and explain all of the risks that could possibly occur. I wish to rely on the Doctor to exercise judgment during the course of chiropractic care on that basis. I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

ANDERSON CHIROPRACTIC DOCTORS:

DR. TOM RYAN D.C.

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5**

**Anderson Chiropractic Group Fee Consent**

*Initial Examination*

Adult $ 99.00

Child/Student $ 89.00

This fee includes cost of consultation, examination and report. Please allot one hour for this initial visit and thirty minutes for the report of findings

*Adjustments*

Adult $ 45.00

Child/student $ 35.00

*Progress Examination & Report* $20.00

*Comparative Examination & Report* $50.00

You are responsible for the fees incurred for each visit at the time the services are rendered. If you have extended health care coverage, please check with your insurance carrier for the particulars of your coverage. It is the policy of this office for the patient/guardian to be responsible for taking care of their account and we will provide you with an itemized statement of the services rendered. We do not bill insurers directly on your behalf. We are also happy to provide you with itemized receipts for income tax purposes.

All new complaints or injuries are assessed as per a new patient with a history and examination to ensure we have the appropriate information to assist you.

Please sign below to indicate that you have read and understood the Investment Schedule. Should you have any questions, please ask front desk staff for further information.

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)**

PARENT(S) NAMES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK TEL \_\_\_\_\_\_\_\_\_\_

I hereby authorize and consent to the chiropractic evaluation of my child.

**PARENT/GUARDIAN SIGNATURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_

WITNESS SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**

Mental/Emotional Stresses

As psychological stress has been shown to negatively affect nervous system function, please let us know how you are coping with life’s stresses. Rank from 1 to 10 with 1 being low stress, 10 being high stress.

Life in general I feel 1 2 3 4 5 6 7 8 9 10 Work and Career I feel 1 2 3 4 5 6 7 8 9 10

Relationships I feel 1 2 3 4 5 6 7 8 9 10 Time management I feel 1 2 3 4 5 6 7 8 9 10

Quality of sleep I feel 1 2 3 4 5 6 7 8 9 10 Health/ well-being I feel 1 2 3 4 5 6 7 8 9 10

If you are experiencing significant or ongoing stress please explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

□ Cancer □ Hypertension □ Stroke □ Arthritis □ Autoimmune Disorder □ Diabetes □ Other

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why Are You Here?

People seek chiropractic care for a number of reasons and have certain expectations and perceptions. Please tick the goals which apply to you so we can accommodate your wishes.

□ Improvement in function □ Pain reduction □ Improved quality of life

□ Wellness □ Relief of Symptoms □ Healthier immune system

□ Stress reduction □ Increased Mobility □ Clear Brain Body Connection

□ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_