ANDERSON CHIROPRACTIC
Accident, Neck, Back & Pain Center

PI 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: ___ 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? _____

Anderson Chiropractic Accident Neck, Back & Pain Center
1110 N Five Mile Rd. Suite 200 Boise, Idaho 83713
(208) 377-0551

Patient Name:_____ **Date:** _____

FAMILY HEALTH HISTORY -- Please indicate if anyone in your family has 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

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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 treatment, 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

Anderson Chiropractic Accident Neck, Back & Pain Center
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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

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Patient Name: _____ Date: _____

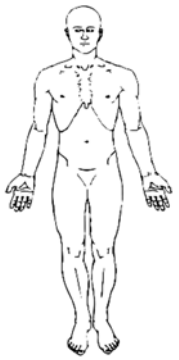
PATIENT SYMPTOM FORM

(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 percentage of the time when you are awake do you experience this intensity? 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- 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		Tilting left at waist		Tilting right at waist
	Sitting		Standing		Getting up from sitting
	Lifting		Chewing		Changing positions
	Lying down		Reading		Working
	Exercising		Laying on side in bed		Driving
	Walking		Running		Nothing

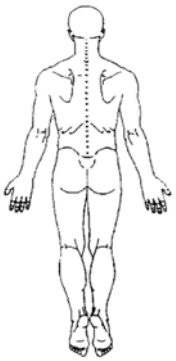


- What makes the symptom better? (check all that apply)

	Ice		Heat		Exercise
	Massage		Pain medication		Muscle Relaxers
	Resting		Stretching		Walking
	Chiropractic adjustments		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		No difference

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?

_____

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Patient Name: _____ Date: _____

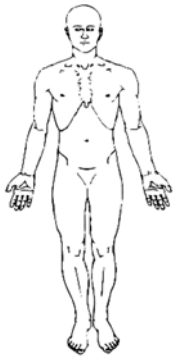
PATIENT SYMPTOM FORM

(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 percentage of the time when you are awake do you experience this intensity? 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- 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		Tilting left at waist		Tilting right at waist
	Sitting		Standing		Getting up from sitting
	Lifting		Chewing		Changing positions
	Lying down		Reading		Working
	Exercising		Laying on side in bed		Driving
	Walking		Running		Nothing

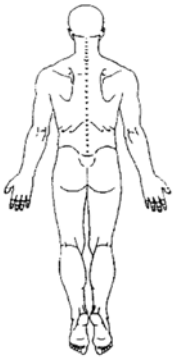


- What makes the symptom better? (check all that apply)

	Ice		Heat		Exercise
	Massage		Pain medication		Muscle Relaxers
	Resting		Stretching		Walking
	Chiropractic adjustments		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		No difference

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?

_____

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Patient Name: _____ Date: _____

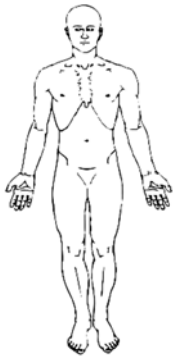
PATIENT SYMPTOM FORM

(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 percentage of the time when you are awake do you experience this intensity? 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- 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		Tilting left at waist		Tilting right at waist
	Sitting		Standing		Getting up from sitting
	Lifting		Chewing		Changing positions
	Lying down		Reading		Working
	Exercising		Laying on side in bed		Driving
	Walking		Running		Nothing

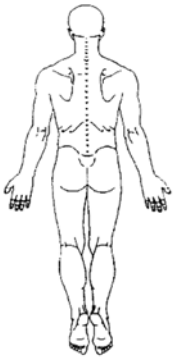


- What makes the symptom better? (check all that apply)

	Ice		Heat		Exercise
	Massage		Pain medication		Muscle Relaxers
	Resting		Stretching		Walking
	Chiropractic adjustments		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		No difference

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?

_____

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(208) 377-0551

Patient Name: _____ Date: _____

AUTO ACCIDENT MECHANISM OF INJURY FORM

Date of Accident/Collision _____ Time of Accident/Collision_____ AM or PM
Please describe how the collision occurred: _____

_____

What were the weather conditions at the time of the accident? _____
What street(s) were you on? _____
What direction were you heading? **N S E W** What direction was the **OTHER** vehicle heading? **N S E W**
What is the Make, Model and Year of the **OTHER** vehicle? _____
What was the approximate speed of the **OTHER** vehicle when the accident occurred? _____mph
Were you the only one in **YOUR** vehicle? If not, who was in **YOUR** vehicle? _____

ABOUT YOUR VEHICLE

What is the Make, Model and Year of **YOUR** vehicle? _____
What was the approximate speed of **YOUR** vehicle when the accident occurred? _____mph
Did you strike another vehicle? **YES or NO** Did another vehicle strike your vehicle? **YES or NO**
What was the angle of impact? (Check one) **___Front ___Back ___Left ___Right ___Other _____**
If second collision, angle of 2nd impact**: ___Front ___Back ___Left ___Right ___Other _____**

ABOUT YOU

What was your position in the car? (check one**) ___Driver ___Front Passenger ___Left Rear ___Right Rear**
If Driver, were your hands on the steering wheel? (check one) **___Both ___Left ___Right**
Did the airbags deploy? **YES or NO**
In relation to the back of your head, was your headrest set **___Low ___Middle ___High**
Were you surprised by the impact? **YES or NO or PARTIALLY**
If, "NO", how did you brace? **WITH HANDS or WITH FEET**
Where was your head facing at the time of impact? **__Straight __Left __Right __Behind __Up __Down**
Were you leaning forward at the time of impact? **YES or NO**
Were you wearing a seatbelt? **YES or NO** What type? **___Lap Belt ___Shoulder belt ___Both**
Were you braking on impact? **YES or NO**
Did you feel pain immediately after the accident? **YES or NO**
Were you rendered unconscious as a result of the accident? **YES or NO**
Did you strike anything in the vehicle at the time of impact? **YES or NO** If yes, specify what part of your body struck which part of the vehicle.

Steering Wheel	Windshield
Dashboard	Roof
Left Side Door	Right Side Door
Left Window	Right Window
Other	

Patient Name: _____ Date: _____

Did your seatbelt break or bend? **YES or NO**
Immediately after the accident, how did you feel? (check all that apply) **__Dizzy __Dazed __Weak __Upset __Disoriented __Nervous __Nauseous __Other_____**
Since the collision, have you experienced any of the following:

Loss of range of motion? **YES or NO** Which body parts? _____
Visual Disturbance? **YES or NO**

Blurring? **L or R**	Floaters? **L or R**	Vision Loss? **L or R**	Hypersensitivity? **L or R**
% of time ____	**% of time ____**	**% of time ____**	**% of time ____**

Dizziness? **YES or NO % of time ____** Anxiety? **YES or NO % of time ____**
Depression? **YES or NO % of time ____** Difficulty sleeping? **YES or NO % of time ____**

Have you missed work as a result of the accident? How many days? _____
Do you have difficulty with **EXCESSIVE?** (check all that apply) **_ Standing __Walking __Riding __Bending __Twisting __Other_____**
Do you have difficulty with **EXCESSIVE** lifting? (check all that apply) **__Light __Moderate __Heavy __Repetitive**

YOUR SYMPTOMS SINCE THE ACCIDENT

Please check ALL SYMPTOMS that apply

__Headache
__Neck stiffness
__Shoulder stiffness
__Pins and needles in arms
__Upper back pain
__Chest pain
__Low back pain
__Buttock pain
__Pins and needles in legs
__Depression
__Irritability
__Loss of memory
__Tremors
__Dizziness
__Loss of smell
__Pain behind the eyes
__Buzzing or ringing in ears
__Shortness of breath
__Vomiting
__Excessive perspiration
__Cold sweats
__Swelling, where? _____
__Difficulty standing
__Difficulty lifting
__Skull or head pain
__Head feels too heavy
__Arm pain
__Numbness in hands and fingers
__Mid back pain
__Rib pain
__Low back stiffness
__Leg pain
__Numbness in feet/toes
__Anxiety
__Nervousness
__Difficulty sleeping
__Face flushed
__Fainting
__Eye strain
__Eyes sensitive to light
__Loss of balance
__Digestive problems
__Diarrhea
__Loss of perspiration
__Fever
__Difficulty riding in car
__Difficulty sitting
__Difficulty twisting/turning
__Neck pain
__Shoulder pain
__Arm numbness
__Cold hands
__Mid back stiffness
__Painful breathing
__Hip pain
__Leg numbness
__Cold feet
__Tension
__Mental dullness
__Fatigue
__Loss of color
__Sinus trouble
__Difficulty focusing
__Double vision
__Palpations
__Nausea
__Constipation
__Loss of taste
__Pain in doing occupation
__Difficulty bending
__Difficulty walking
__Difficulty rising to walk

Patient Name: _____ Date: _____

POLICE & HOSPITAL

Was the accident reported to the police? **YES or NO** Were citations issued? **YES or NO** To whom?_____
Did you go to the hospital? **YES or NO** If "YES", how? **__Ambulance __Police Car __Private Vehicle**
Were you admitted to the hospital? **YES or NO** If "YES", how long did you stay? _____
Name of Hospital? _____ Attending Physician? _____
What treatment were you given? (check all that apply) **__None __X-ray __MRI __CT __Pain Medication**
__Stitches __Muscle Relaxants __Bandages __Cervical Collar __Physical Therapy
__Instructions for Concussion __Instructions for Strains/Sprains __Referred to an Orthopedist
__Referred to a Private Physician __Referred to this Office __Other _____
What other Doctor have you seen as a result of this injury? _____

YOUR PERSONAL INJURY POLICY (PIP)

PLEASE CHECK ONE:

_____ Bill my automobile policy under the Med Pay

_____ I will pay by check/cash/card as services are rendered and I will forward them to the proper insurance company myself.

Unless you have elected to pay cash/check/card for your treatment, your care will be billed to your automobile insurance carrier under your Med Pay coverage. Your Med Pay coverage will pay medical expenses as a result of the accident up to policy limits. This coverage is for your protection so that the bills will be paid in a timely manner. **If the accident was not your fault**, your insurance company will be reimbursed upon settlement by the responsible party's insurance.

Is an attorney representing you for this accident? YES or NO, Who? _____
What is the name of YOUR insurance company? _____
What if the name and phone # of YOUR claim adjustor? _____
_____
What is your claim #? _____

My signature below acknowledges that I understand and accept the above policy and give permission for my Med Pay coverage to be billed for medical services performed related to my accident.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Guardian

Patient Name: _____ Date: _____

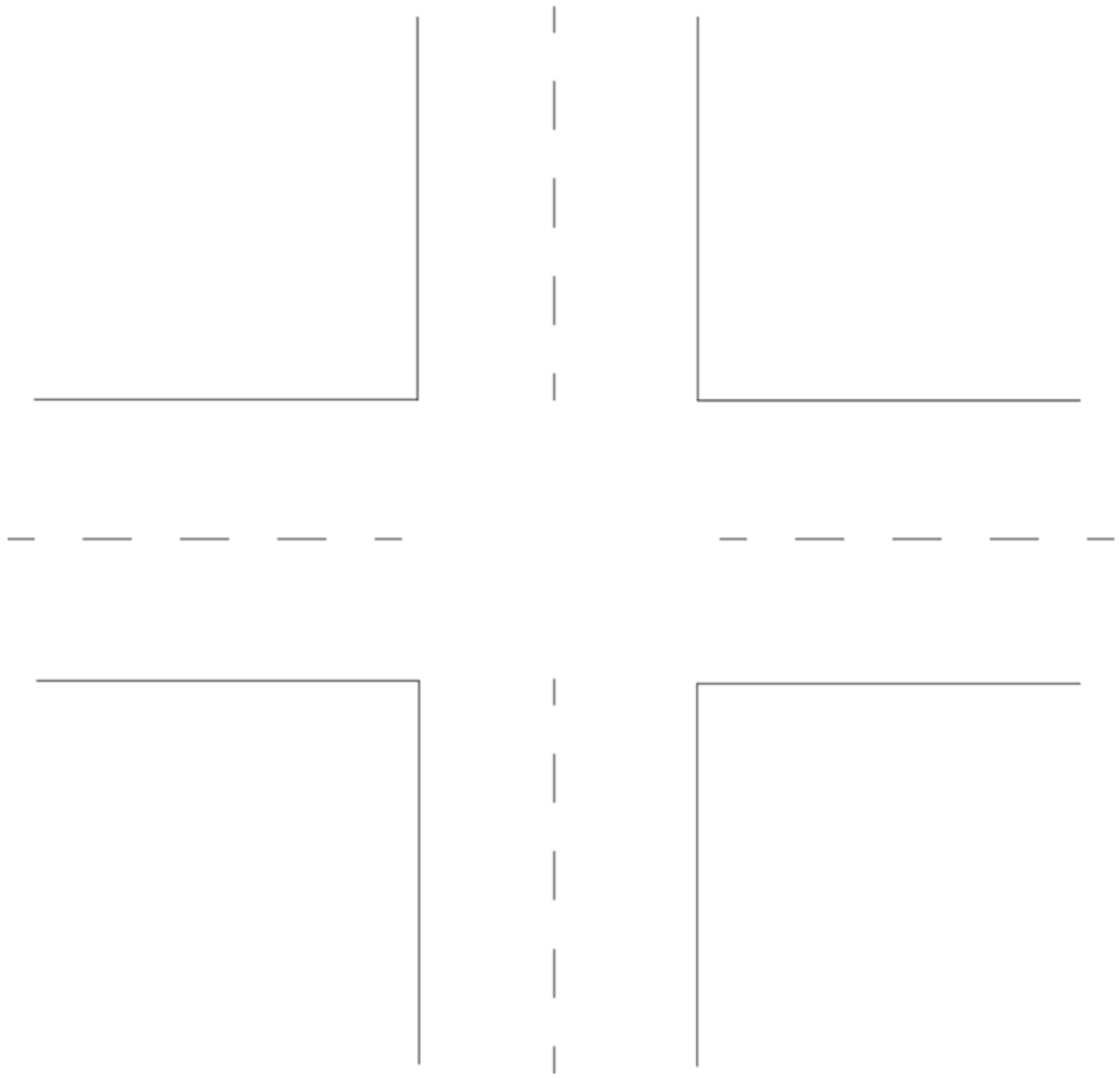

Diagram The Collision

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