WELCOME TO OUR OFFICE

Confidential Patient Information

Date: _____

First Name:_____ Nickname:_____ Middle Name:_____ Last Name:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): (____)_____ (Work): (____)_____ (Mobile): (____)_____

Email: _____ Birth Date: _____ Sex: M / F Marital Status: S / M / W / D

Spouse Name: _____ Number of Children: _____ Referred To Our Office By: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Contact Relation:_____ Contact Phone:_____

Best Way to Contact You For Confirming Future Appointments:

____ ***By Text:*** Mobile Phone Provider: _____ ____***By Email*** ____***By Phone:*** __ Mobile __ Home __ Work

Primary Insurance:_____ Policy ID #_____ Group #_____

Purpose For This Visit / Chief Complaint:_____

How is This Affecting Your Life / Activities? _____

When Did It Begin? _____ How Did It Begin?_____

Other Doctors Seen For This Condition?_____ Treatment _____

Have You Ever Had A Similar Condition? Y / N _____ Type Of Pain: __Dull __Ache __Sore __Stiff __Sharp __ Numb __Burn

How Often Do You Feel The Pain? ___Constant (76-100%) ___Frequent (51-75%) ___ Intermittent (26-50%) ___ Occasional (0-25% Of The Time)

What Increases Pain: __Sitting __Standing __Walking __Lifting __Changing Position __Computer __Driving __Exercise __Weather

Other Aggravating Factors: _____

Is The Pain/Discomfort Worse At Certain Times Of The Day? Y / N If So, When: _____

What Eases The Pain? __Rest __Lying Down __Cold __Heat __ Chiropractic __Massage __Medication:_____

Indicate All Your Desired Outcomes As A Result of Your Treatment in Our Office:

__Reduce Pain
__No Residual Pain
__Minimal Activity Limitations
__No Activity Limitations
__Future Recurrence Minimized
__Condition Fully Resolved
__Lifestyle Changes To Prevent Recurrence
_____
_____

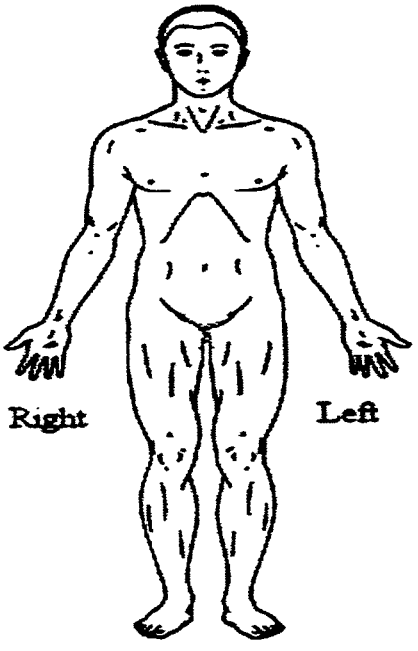
Have You Had Previous Chiropractic Care? Y / N Condition Treated_____ Last Treatment Date_____

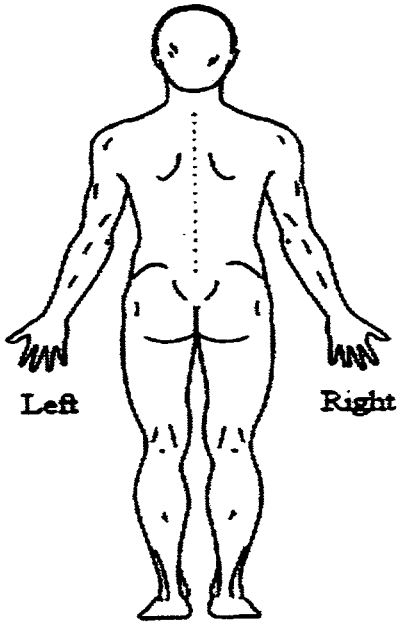
Patient or Parent / Guardian Signature: _____ **Date:** _____

Confidential Health History

Name: _____ Date: _____

Pain Locations: Indicate Any Current or Recent Areas of Pain in Your Body on The Drawings and On The List





__Headache
__Sinus
__Jaw
__Tooth
__Neck
__Throat
__Chest
__Shoulder
__Arm
__Elbow
__Wrist
__Hand
__Finger
__Upper Back
__Mid Back
__Low Back
__Abdomen
__Pelvis
__Hip
__Thigh
__Knee
__Lower Leg
__Ankle
__Foot
__Toe
Other _____

Please Indicate Pain Severity (0 = No Pain to 10 = Worst Pain)

Conditions You Have Had:

☐ Allergies	☐ Diabetes	☐ Neck Pain	☐ Sinus Troubles
☐ Alcoholism	☐ Digestive Disorders	☐ Neuritis	☐ Stroke
☐ Anemia	☐ Dizziness	☐ Nervousness	☐ Tuberculosis
☐ Arthritis / Joint Pain	☐ Epilepsy	☐ Numbness	☐ Ulcer
☐ Asthma	☐ Fatigue	☐ Parasites	☐ Urinary Trouble
☐ Backaches	☐ Headaches	☐ Poor Appetite	☐ Venereal Disease
☐ Breathing Problems	☐ Heart Trouble	☐ Poor Circulation	☐ Weight Loss
☐ Cancer	☐ High Blood Pressure	☐ Prostate Problems	☐ Yeast / Candida
☐ Depression	☐ Hypoglycemia	☐ Rheumatic Fever	☐ _____

Height: _____ Weight: _____ Date of Last Physical Exam: _____ With Whom: _____

Reported Findings: _____

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): _____

_____

Fractures, Dislocations, Major Dental Work (List Year in Brackets): _____

Have You Been Treated For Any Other Condition in The Past Year? Y / N (If So, Describe): _____

Medications / Drugs You Are Taking: _____

_____

Current Vitamins, Minerals, Herbs: _____

_____

Additional Health History

Name: _____ Date: _____

Family Health History: *Please Indicate Diagnosed Health Conditions And Untimely Deaths Of Your Blood-Related Family Members*

__Alzheimer's	__Cancer	__High Blood Pressure
__Arthritis	__Diabetes	__Parkinsons
__Autoimmune Condition	__Cardiovascular Disease	_____
__Dementia	__High Cholesterol	_____

Known Allergies: _____

Daily Life:

Do You Sleep Well? Y / N If No, Describe: _____ Average Hours / Night: ____

Do You Have Sufficient Energy For Normal Activities? Y / N If No, Describe: _____

Do You Smoke? Y / N What? _____ How Many / Day: _____ Since When? _____

Drink Coffee? Y / N Cups / Day _____ Drink Caffeinated Tea? Y / N Cups / Day _____

Colas / Soft Drinks? Y / N Number / Day _____ Glasses of Water / Day: _____

Alcoholic Beverages? Y / N Avg. No. / Wk _____ Mostly What? _____

Do You Eat Red Meat? Y / N Are You a Vegetarian? Y / N If So, For How Long? _____

Are You Dieting? Y / N If So, Describe: _____

Do You Eat in Fast Food Restaurants? Y / N If So, How Many Times / Week: _____

Has Your Vision Changed Recently? Y / N Explain: _____

Do You Wear Heel Lifts Or Foot Supports? Y / N Explain: _____

Bowel Movement Frequency: _____ Difficulty? Y / N Approximate Number of Times You Urinate / Day: _____

Exercise:

What Sports Do You Enjoy Now? _____

Are You In Training For A Particular Sport? Y / N Describe: _____

Describe Your Exercise Program: _____

_____

WOMEN ONLY: Menstrual History

Age At Onset: _____ Are Your Periods Regular? Y / N Cycle: _____ Days (Start To Finish) Use Birth Control Pill? Y / N

Your Flow Is: Heavy Medium Light Date Of Last Period: _____ Cramping? Y / N

PMS? Y / N If So, What: _____

Other Menstrual / Hormonal Symptoms: _____

Are you pregnant, or have you had any signs of pregnancy? Y / N _____

Anything Additional About Your Current Health or Stress Levels: _____

_____

_____

_____

_____

ACTIVITIES OF DAILY LIVING

For each activity, please circle the description that most closely describes how your pain or symptoms affect your life.

Activity	0	1	2	3	4
Mental Concentration	No difficulty	Slight difficulty	Moderate difficulty	A lot of difficulty	Cannot concentrate
Sleep	Perfect	Mildly disturbed	Moderately disturbed	Greatly disturbed	Totally disrupted
Sitting	Can sit as long as I like	Can only sit 1 hour	Can only sit 30 minutes	Can only sit 10 minutes	Unable to sit due to pain
Standing	No pain after several hours	Pain after several hours	Can only stand 1 hr	Can only stand ½ hr	Pain with any standing
Travel / Driving	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
Walking	No pain any distance	Pain after 1 mile	Pain after ½ mile	Pain after ¼ mile	Pain with all walking
Washing / Dressing	No restrictions and no pain	Mild pain, but no restrictions	Need to go slowly due to moderate pain	Need assistance due to pain or limitations	Require 100% assistance
Bending / Moving	No movement restrictions or pain	Mild pain, but no restrictions	Difficult to bend or change position	Bending or moving causes lingering pain	Unable to move more than a little
Lifting	No pain with heavy weight	Pain with heavy weight	Pain with moderate weight	Pain with lifting light weight	Pain with any lifting or bending
Work	No limitations and can do extra work	Can do usual work with difficulty	Can do 50% of usual work	Can do 25% of usual work	Cannot work
Social Life	Normal	Normal, but increases my pain	Energetic activities are limited	Stay home most of the time due to pain	Pain restricts me to my home
Recreation / Sports	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

Name _____ Date _____ Add Numbers to Get Total Score _____

Acknowledgement for Use and Disclosure of Protected Health Information and Consents to Chiropractic Evaluation, Treatment and Financial Policies

Notice of Privacy Practices I have read and understand the Notice of Privacy Practices for Dr. Derik Sanders; ***"Your Information. Your Rights. Our Responsibilities."*** which describes how my Protected Health Information may be used or disclosed. I understand that I may request a copy of the Notice from Dr. Derik Sanders at any time.

Informed Consent and Authorization for Chiropractic Evaluation and Treatment I understand that although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, there are possible risks and complications associated with these procedures. I have read and understood the description of common risks associated with these procedures. I hereby authorize Dr. Derik Sanders to perform the history, diagnostic and examination procedures they deem necessary related to conditions presented in this office.

I understand that the doctor has the right to refuse or accept me as a patient at any time before treatment begins. Should they accept me for treatment, I give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that chiropractic procedures may consist of adjustments involving movement of the joints and soft tissues. Adjunctive physical therapy, exercises and nutritional therapy may also be used in my treatment. I understand that there may be additional risks associated with any of these forms of treatment. Should I have any adverse reactions to treatment, I will notify my doctor as soon as possible. I intend this consent to apply to all present and future chiropractic care received in this office.

Non-Covered Services Policy I understand that some of the services or supplies I receive from Dr. Derik Sanders may not be approved for reimbursement by insurance companies. If such is the case, I will be informed in advance of these items. Should I then choose to utilize these supplies or services, they will not be billed to my insurance company and will be my sole financial responsibility.

Informed Consent of Appointment Scheduling Policies If I discover that I am not able to make a scheduled appointment, I will notify Dr. Derik Sanders at the earliest possible opportunity. I understand that if I miss an appointment or fail to provide twenty-four hours notice prior to canceling or rescheduling an appointment, I will be responsible for paying for that appointment in full.

Authorization for Direct Payment to Dr. Derik Sanders Should I have an outstanding balance on my account with Dr. Derik Sanders, I authorize direct payment of my medical benefits to Dr. Derik Sanders for the health care services rendered to me. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that I am personally responsible for these services should they not be covered by insurance.

Signature
I have reviewed and agree with this consent form. I also give my permission to this office to use and disclose my health information in accordance with the described Protected Health Information Policies described.

Name of Patient (print)	Signature of Patient (Or Patient Parent/Representative)	Date
	Office Representative	Date

Credit Card Authorization Form

I have decided to use a new billing software called OpenEdge to store credit card information and receive payments. From now on, I will no longer need you to fill out your credit card information since the new system I have implemented will store this automatically when you swipe your card in the card reader. OpenEdge will protect your sensitive payment data by using a multi-pronged approach incorporating EMV, QIR, encryption, tokenization and more. This system is PCI compliant, meaning that it ensures that the processing and storage of this information meets the set security standards.

Using OpenEdge to store this information will simplify and expedite the previously time consuming payment process, allowing me to spend more time focusing on providing you with the best care possible.

If for any reason you would prefer your credit card information not to be stored, please contact me so that I can make the appropriate changes to your payment settings. This authorization will remain effective until cancelled.

If you agree with my office storing your credit card information through OpenEdge, please sign the statement below.

I, _____ authorize Derik Sanders, DC to charge my credit card for the agreed upon purchases. I understand that my information will be safely stored for future transactions on my account.

_____ _____

Patient Signature Date