Patient Information

Name: _____	***Birthdate***:_____
Address_____	***Your Employer***:_____
City/ST/Zip: _____	***Occupation***:_____
Cell Phone:(_____)_____	***Work Phone***: (_____)_____
Home Phone:(_____)_____	***Email Address:***___ _____
Spouse's name:_____	***Spouse's employer***:_____

Please tell us who referred you to Dr. Anderson:_____

Describe your problem:

_____

When did you first notice it?

_____

What drugs have you taken and who prescribed them?

_____

What other treatments have you received and who performed them?

_____

Has any treatment helped?_____(females)Are you pregnant?_____

List EVERY drug you NOW take and what it is for (including other illnesses):

_____

List EVERY surgery that you have had (including childhood and non-back surgeries):_____

_____

Please read this notice: *This information is provided for your understanding and to clarify the* ***financial policies*** *at Anderson Chiropractic. This way we can devote our efforts to helping you get the best results in the shortest amount of time.*

We accept cash, personal checks and Visa, MasterCard, Discover & American Express. Patients are responsible for full payment at the time of service. Any other payment arrangements must be pre-authorized.

If your care is covered by group insurance or a third party, we will supply statements, reports and other documents to help you receive benefits. Please remember that all professional services are rendered and charged to the patient receiving care, not the third party. In addition, we will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" and "not medically necessary" charges, etc., other than to supply factual information. Should x-rays be indicated, our office is equipped to take them. State law requires the originals remain permanent property of the office. Should you need copies for your primary care physician or for your personal use, we will gladly supply copies after a $20 prepayment is made to cover copy film and processing.

Any outstanding balances are billed monthly on the first of each month and are due 10 days after the invoice date. Returned checks are subject to a $10.00 fee. Balances unpaid for more than 60 days will accrue interest charges of $5 per month, plus any legal or collection fees.

I have read, understood, agreed to, and received a copy of this agreement.

_____ _____ _____

Patient/Guardian Signature Date Witness

Progress Report

Name:_____ **Date:**_____

Please mark the level of intensity of your symptoms using the following scale.
(0 equals no symptom at all, 100 equals maximum *possible* intensity of the symptom.)

Example: Symptom: Headache above my eyes

0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

Symptom:_____
0 10 20 30 40 50 60 70 80 90 100

How much are your symptoms preventing you from doing what you would normally do during the day?
For each of the categories of daily living listed, mark the level which describes your typical level of activity.
(0 means no change in your level of function, 100 means you cannot function because of your symptoms.)

Family/Home (Chores around house/yard, taking kids to school, running errands, grocery shopping, etc.)
0 10 20 30 40 50 60 70 80 90 100

Recreation (Hobbies, sports, & leisure activities.)
0 10 20 30 40 50 60 70 80 90 100

Social Activity (Parties, theater, concerts, dining out, and other social functions, etc.)
0 10 20 30 40 50 60 70 80 90 100

Occupation (job related activities, including non-paying jobs such as homemaker or volunteer work.)
0 10 20 30 40 50 60 70 80 90 100

Self Care (taking a shower, getting dressed, etc.)
0 10 20 30 40 50 60 70 80 90 100

Life Support Activity (eating, sleeping, breathing,etc.)
0 10 20 30 40 50 60 70 80 90 100

_____
Patient Signature