Anderson Family Chiropractic
8088 Douglas Avenue
Urbandale, IA 50322

WELCOME

Date____/____/_____
Patient #________

Chiropractic… More than an adjustment, it's a way of life!

Mission

As your Chiropractor, My mission is to locate and bring about the correction of vertebral subluxations for the removal of interference to your nervous system, educate you on the benefits of a healthy lifestyle, and help you maximize your body's God-given potential to live love, and grow.

PATIENT INFO

Name____
Last First M.I.
I prefer to be called _____________________

Address_______________________________________

____
City State Zip Code
Home Phone # _______________________
Cell Phone #_________________________

E-mail address:_________________________________

Sex:____ **Age**_____ **Birth date**____/_____/____

Patient **SSN**_________-_______-_____________

Occupation___________________ FT PT

Employer____
Employer Address _______________________________

Whom may we thank for referring you?
____

Emergency contact:

Name:________________________________
Phone #: _______________ Relation: _______________

Spouse (if married) -OR- Parent (if patient is a minor)

Name: ____
Last First MI
SSN_______-_____-___________
Birth date ____/_____/____
Occupation _______________________________
Employer_________________________________
Phone Number: _(____)_____-___________

Doctors

Chiropractor ______________________________________
Name City State
Date of last Visit: _________________________
Reason for last visit: _________________________________

Medical Dr. ____
Name City State
Date of last visit________________________
Reason for last visit:
____

Accident Information

Is this condition due to an accident? Yes / No
Date of accident ___/____/___ Type ______________
To whom have you made a report?
Please circle: Auto Insurance Employer Other
Attorney name______________________________
Phone Number_(____)________-____________

What are your goals for your healthcare here at Anderson Family Chiropractic?

□ Wellness/ preventative care □ Pain Management □ Other (please list)____

PAST HISTORY (please include dates)

Accidents: ____
Surgeries: ____
Medications: ____
Supplements: ____
Hospitalizations: ____

Are you: Pregnant? Yes / No Week # ____ Nursing? Yes/ No
Do you: Smoke? Yes / No Packs per day ______ Exercise? Yes / No Hours per week ___
Drink Caffeine Yes / No Cups /Cans per day ______ Alcohol? Yes / No Drinks per week ____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes. I authorize the Doctor, and staff to perform any necessary services that I may need during diagnosis and treatment with my informed consent.

Signed _______________________________ Date____/____/________

Patients Name________________________________ **(Please complete questions in blue box below)** Pt ID # _______

Present Concern(s) ____
____

Where exactly is the problem? ________________________ When did the problem begin? _________________________

Have you ever experiences this problem before? (Yes / No) When?____________
Is this problem getting worse? Yes / No / Not sure Rate your pain: 1----------------5---------------10 <
No Pain Severe

Does anything make it: Worse? ____
Better? ____
What treatment(s) was/ are being provided? ____
Is this due to injury? (Yes / No) How did you injure yourself? _____________________________

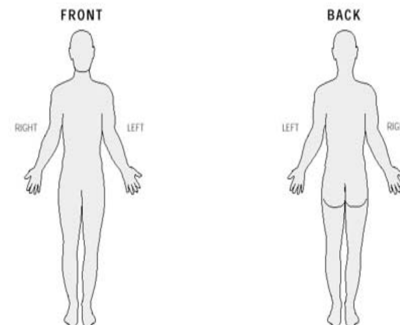
For the following questions check all that apply.

Type of Pain:
☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Burning

☐Shooting ☐Tingling ☐Cramps ☐Other: ______________

Does it interfere with your:
☐Work ☐Sleep ☐Daily Routine ☐ Recreation

Activities or movements that are painful to perform:
☐Sitting ☐**Standing** ☐**Walking** ☐**Bending** ☐**Lying down** ☐**Lifting** ☐



Mark all areas that have pain.

Please check all symptoms that you are experiencing or have experienced, even if they seem unrelated to your problem area:

☐Headache	☐Nervousness	☐Fainting	☐Menstrual pain	☐Back Pain
☐Dizziness	☐Tension	☐Hot Flashes	☐Menstrual Irregularity	☐Numbness in legs
☐Fatigue	☐Loss of balance	☐Pins and needles	☐ Problem urinating	☐Numb/cold feet
☐Sleeping problems	☐Loss of smell	☐ Numbness in fingers	☐Stomach upset	☐ Other: ___________
☐Mood Swings	☐Buzzing in ears	☐Cold hands	☐Heartburn	___________
☐Depression	☐Cold sweats	☐Stiff neck	☐Ulcers	
☐Irritability	☐Ringing in ears	☐Neck pain	☐Diarrhea	
☐Fever	☐Loss of taste	☐Light bothers eyes	☐Constipation	

Have you ever been diagnosed with an illness or condition? (i.e. Cancer, Arthritis, Stroke, Heart disease, High Blood Pressure, Scoliosis, etc.)? If yes, please list here:____

Muscle Tests (1-5

Level	Muscle	Grade
C5	Deltoid	R___ L___
C6	Biceps	R___ L___
	Wrist Exten	R___ L___
C7	Triceps	R___ L___
	Wrist Flex	R___ L___
	Finger Extensors	R___ L___
C8	Finger Flexors	R___ L___
T1	Finger Abductors	R___ L___
L2-3	Hip Flexors	R___ L___
L4-5	hip Extensors	R___ L___
L3-4	Knee Extensors	R___ L___
L5-S1	Knee Flexors	R___ L___

Ht __'___" *Wt*____

*Blood Press*____/____
*Last B/P test*____________

Range of Motion (in degrees) & Strength test (1-5)

	Motion	Norm	ROM	Pain	Strength
Cervical	Flexion	45	______	☐	☐ = ☐
	Extension	55	______	☐	☐ = ☐
	Lat Bend	45	R___ L____	☐	☐ = ☐
	Rotation	70	R___ L____	☐	☐ = ☐
Thor/Lumb	Flexion	90	______	☐	☐ = ☐
	Extension	55	______	☐	☐ = ☐
	Lat Bend	45	R___ L____	☐	☐ = ☐
	Rotation	70	R___ L____	☐	☐ = ☐

	Test	R	L	(+/-) Indication
Cervical	Distraction	☐	☐	Nerve root comp
	Compression	☐	☐	Nerve root comp
	Shoulder depress	☐	☐	Nerve root comp
Lumb/Pelv	S.L.R.	☐	☐	Lumbar Disc
	Minors Sign	☐	☐	Radic Disc Pain
	Kemps	☐	☐	IVD rupture
	Adams (Sup)	☐	☐	LumboSacral Differentiation

Reflexes (0, +1, +2, +3)

Biceps	(C5-6)	R__ L__
Brac/Rad	(C5-6)	R__ L__
Triceps	(C7-8)	R__ L__
Patellar	(L2-4)	R__ L__
Achilles	(S1-2)	R__ L__

Comments
____
____
____
____
____
____
_____
Dr. ______________
Date / / 200