ANDERSON UPPER CERVICAL

1099 MERCHANTS DRIVE, SUITE A, DALLAS, GEORGIA 30132-3005
PHONE: 770-443-0787 ~ FAX: 770-443-3890 ~ EMAIL: info@andersonuc.com

CS#_____

PATIENT INFORMATION

Name:_____ DOB:_____ Date:_____

Hm Ph #:(___)_____ Cell Ph #:(___)_____ Sex: ____ M ____ F

Is it ok to contact you at work? _____Yes _____No Wk Ph #:(___)_____

Address:_____ City:_____ State:_____

9 digit Zip:_____ - _____ SS#:_____ Email: _____

Preferred Appt Reminder Method: ____ Text to cell # above _____ Email ____ Phone Call to cell # above ____ NONE

Your Occupation:_____ Employer:_____

Marital Status: S M D W Spouse's Name:_____

Spouse's Occupation:_____ Spouse's Employer:_____

Spouse's Wk Ph#:(_____)_____ Insured's Name:_____

Insured's DOB:_____ Insured's SS#:_____ Insured address:_____

Number of Children _____ Ages of Children:_____

Have You Ever Received: General Chiropractic Care? ___Yes ___No Upper Cervical Care? ___ Yes ___ No

If Yes to either: When was your last visit? _____ Doctors' name? _____

Is today's appointment related to an injury at ___ Work/School ___ Sports ___ Auto ___ Home ___ Other (_____)

Is there an open case for this accident with your employer, auto/home owners insurance company, or attorney? __ Yes __ No

Injuries/Surgeries You've Had	**Description AND Year for EACH** **[enter "n/a" if doesn't apply]**	**Do you feel your *present symptoms* are related to this event?**
Accidents		
Falls / Injuries		
Broken Bones		
Surgeries		

How did you originally hear about us?

____ Referral [Name of person(s) so we may thank them: _____]

____ AUC Website ____Facebook ____ Google ____ Healthgrades _____ Other [Specify: _____]

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Present major complaint(s): _____

Rate the severity of your pain on a scale of 1(least) to 10 (severe)? _____ Date symptoms began: _____

For our female patients: Are you pregnant? _____ Yes (if yes, # wks/Due Date:_____) ____No ____ Possibly

Date of Last Period: _____ Are you in peri/full menopause? _____Yes _____ No

Check any other symptoms you Currently Have or Have Had in the last 5 years:

	Arthritis		Dizziness		Herniated disk (s)		Poor posture
	Allergies		Depression		High /Low blood pressure		Pins & needles in arms / legs
	Asthma		Difficult digestion		High cholesterol		Rapid heart beat
	Back pain		Difficulty breathing		Heart problems		Sleeping problems
	Breast pain/lump(s)		Earaches		Hands or Feet cold		Stroke
	Cancer		Fatigue		Kidney infections/stones		Sinus infections
	Chest pain		Frequent colds		Liver trouble		Stomach pain
	Chronic pain		Frequent nausea		Loss of balance		Shoulder pain
	Constipation		Frequent urination		Neck pain		Thyroid problems
	Diabetes		Headaches /Migraines		Numbness in fingers/toes		Other (Specify):

Please circle the words in ( ) that best completes the statements:	If circled "***used to but no longer***" please tell us the year you stopped:
I (used to but no longer / currently) smoke cigarettes, vape, pipe, cigar, dip, chew, etc.	
I (used to but no longer / currently) drink alcohol.	
I (used to but no longer / currently) have a lot of mental stress in my life.	
I (used to but no longer / currently) have a lot of physically stressful things in my life.	
I (used to but no longer / currently) to get sick a lot.	
I (used to but no longer / currently) exercise.	
I (used to but no longer / currently) consume caffeine (i.e., coffee, sodas, energy drinks).	

Sleeping Posture (circle all that apply): Side Stomach Back

Please list any prescriptions/OTC drugs/medications you are taking & indicate how long you've been taking each: _____

_____

_____

Is there a family history of: Heart disease Arthritis Cancer Diabetes Other _____

Father's side _____ _____ _____ _____ _____

Mother's side: _____ _____ _____ _____ _____

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ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can damage your health expression as well as your nerve system. Following your report of findings visit, your Upper Cervical Doctor will determine if we can accept your case and if so, outline a course of care to begin to correct these layers of damage and recover your innate health potential.

TERMS OF ACCEPTANCE

When a patient seeks Upper Cervical health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Upper Cervical Care has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Upper Cervical method of correction is by specific adjustment of the spine only when and where indicated.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae of the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do **NOT** offer to diagnose or treat any disease or condition other than vertebral subluxation. Nor do we offer advice regarding treatment prescribed by others. However, if during the course of the Upper Cervical chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will alert you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Financial Responsibility: Ultimately, **ALL** services rendered to you are **your** responsibility [if patient is a minor, responsibility is that of the parent/guardian signing this document]. We will do our part in submitting services to your insurance company (ies) and/or attorney when applicable. However, if your account becomes delinquent (i.e. no payment has been made for 3 months or more), we reserve the right to send it along with any incurred fees to collections.

I, _____have read and fully understand the above statements.
(Print Patient Name)

RELEASE OF INFORMATION: In accordance with HIPPA regulations, I authorize this clinic to release any information necessary to process this claim.

_____ _____
(Patient Signature) (Date)

_____ _____
(If patient is a minor, signature of parent/legal guardian) (Date)