

Dr. Houston C. Anderson, DC, MS

OFFICE POLICIES

APPOINTMENTS:

One of my goals is to resolve your health issue(s) by understanding the cause of your problem(s), rather than just treat your symptoms. The success of this goal depends in part on your ability to follow through with instructions for changes to be made between visits. It is also important for you to keep the scheduling of your next office visit as close as possible to the recommended time of your return. If a follow-up appointment must be canceled, no charge will be made if notice is given at least 24 hours in advance (48 hours for new patient appointments). If this is not done, a one-hour visit fee will be charged.

I do my best to run on time. I work with each patient until I accomplish what needs to be done in that session, therefore I sometimes run behind.

FEES, BILLING, & PAYMENT:

Office visit packages as well as individual appointments are available. Payment is due at the end of each session. You are solely responsible for the charges you incur in the office. Upon request, you will be given forms to submit to your insurance company to do your own filing, so you receive the reimbursement you deserve based upon your policy limits. The insurance codes will reflect services provided during treatment. If you are a Medicare patient, you will be asked to fill out a Beneficiary Notice during each visit to acknowledge that our services are not currently covered under Medicare. If you have questions regarding this please ask before your initial visit. I am not a participating provider of any insurance plan.

EMERGENCIES:

In case of emergency, please call the office (480) 242-2536 and leave a message. Your call will be returned as soon as possible. In the event that I do not return your call in a timely manner or it is a life-threatening emergency, you should go to your local emergency room or call 911.

CONFIDENTIALITY:

Our work together is completely confidential, as are your records. Your explicit permission is required to release information about your treatment to doctors, insurance companies, family members, or others.

PLEASE SIGN BELOW INDICATING THAT YOU HAVE READ, UNDERSTAND, and FULLY AGREE TO THE ENTIRE CONTENTS OF THIS PAGE, INCLUDING THE INITIAL 48 HOUR CANCELLATION FEE CHARGE and SUBSEQUENT 24-HOUR CANCELLATION POLICY. THIS FORM MUST BE IN OUR OFFICE ONE WEEK PRIOR TO YOUR FIRST APPOINTMENT.

Name (printed): _____

Name (signed): _____ Date: _____

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HEALTH QUESTIONNAIRE

Personal Information

Full name _____ Name you wish to be called _____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail: _____

Date of birth ____/____/____ Gender: M / F Insurance Company: _____

Occupation: _____ Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

What brings you to my office? _____

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition? _____

Have you had this or similar conditions in the past? _____

What makes it better? _____ Worse? _____

Is the condition getting worse? _____ Constant? _____

Worse at a certain time of day? _____

Is this condition interfering with: Work? _____ Sleep? _____ Activity? _____ Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

Health History

List other current health issues & problems: _____

List other practitioners seen, treatments, self-care activities, and results: _____

List illness you have had not previously mentioned, if any: _____

List all surgeries you have had, with dates and results: _____

Have you ever been in an accident or seriously injured? (if so, please describe) _____

Do you have any dental or TMJ problems? Y N (if so, please describe) _____

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N

(if yes note which teeth) _____

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (please bring actual bottles w/pills in with you to your appointment):

List all medications and other substances (i.e.: foods) to which you are allergic: _____

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother _____ Children _____

Grandparents _____ Brothers _____ Sisters _____

General

*Describe your use of: Cigarettes/Tobacco _____ Alcohol _____ Other drugs _____

*Describe your present exercise habits including frequency per week, duration, and heart rate: _____

* How many hours per night do you sleep? ____ * Do you fall right asleep? Y N * Do you wake up feeling refreshed? Y N

* Do you sleep through the night without awaking? Y N * Do you remember your dreams? Y N

* Do you snore? Y N *Do you have night sweats? Y N * Do you have nightmares? Y N

* Do you grind your teeth at night (bruxism)? Y N * Do you have Restless Legs (RLS)? Y N

*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

*Cholesterol or other blood tests _____ *Pap smear _____

*Mammogram _____ *Prostate Exam _____ *Other _____

Pain Questionnaire

(Skip to the next section if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain.
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache

B = Burning

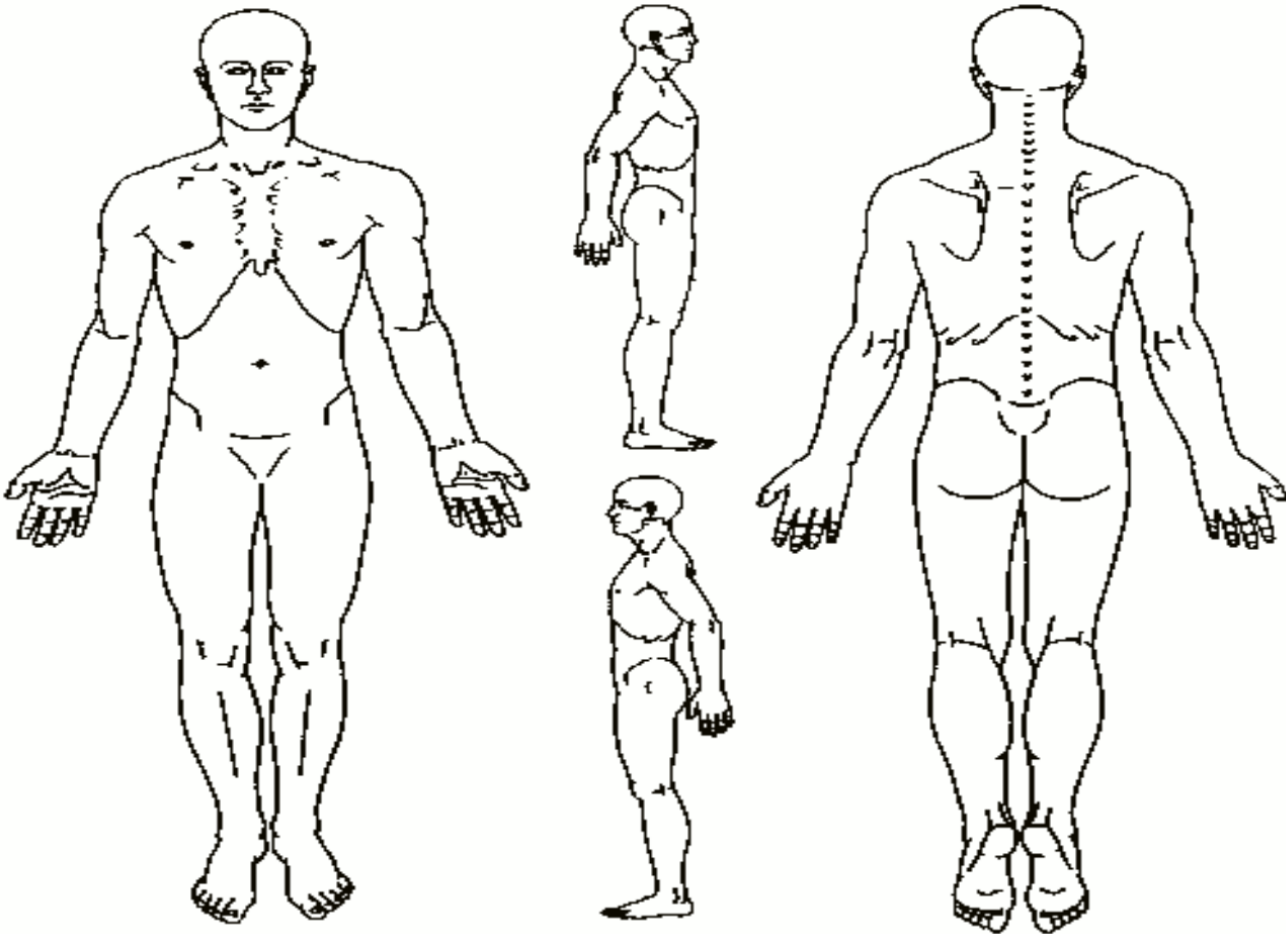
N = Numbness

O = Other

P = Pins & Needles

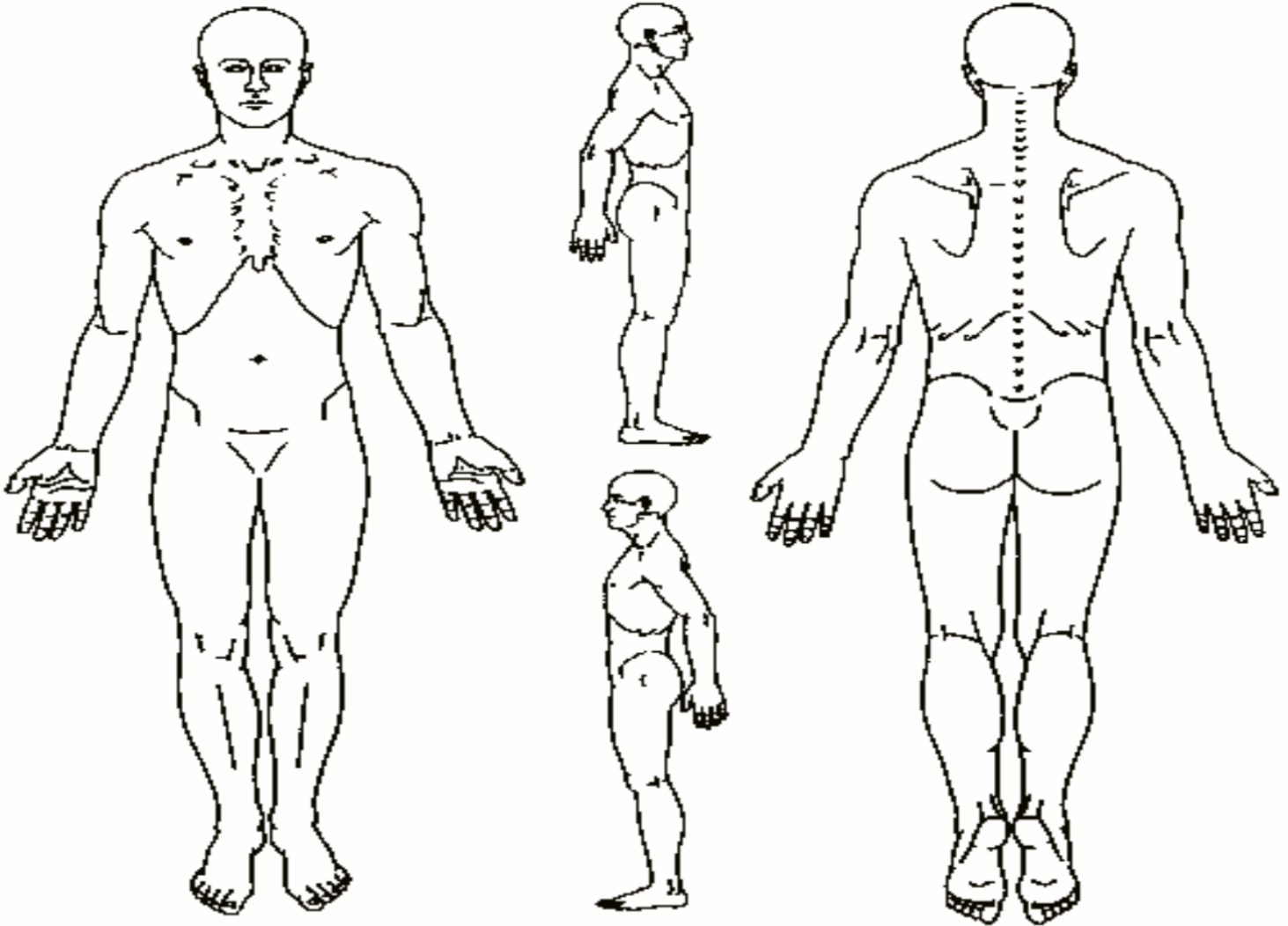
S = Stabbing

T = Throbbing



History of Injury

Please mark with an "X" all the places on your body which have ever been injured (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

GENERAL

- Low energy -fatigue
- Weakness
- Fever - Chills
- Headaches
- Lack of sleep
- Reduced mental acuity

SKIN

- Dry skin
- Itching
- Varicose veins
- Cold or canker sores/fever blisters
- Boils
- Hives
- Rashes
- Sores
- Change in your skin/nails

EYES

- Cataracts/Glaucoma
- Eye pain
- Double vision
- Far or near sightedness
- Flashing lights
- Spots, specks, or floaters

EARS

- Ear discharge/excessive wax
- Earaches or infections
- Hearing loss
- Ringing/tinnitus
- Vertigo/dizziness

NOSE/SINUS

- Sinus congestion
- Frequent colds/infections
- Nosebleeds

NECK

- Goiter
- Lumps
- Pain/stiffness
- Swollen glands

RESPIRATORY

- Asthma
- Bronchitis
- Cough
- Pneumonia
- Tend to hold breath
- Wheezing
- Sputum
- Trouble breathing w/exercise

CARDIAC / VASCULAR

- Arrhythmia
- Chest pain
- Heart trouble
- Murmur
- High blood pressure
- Palpitations
- Shortness of breath
- Swollen feet or lower legs
- Racing or pounding heart
- Blood clots
- Leg cramps
- Poor circulation

MOUTH/THROAT

- Bleeding gums
- Dentures
- Tooth decay
- Frequent sore throats
- Grind teeth at night
- Hoarse voice/frequent loss of voice

NEUROLOGIC

- Blackouts
- Fainting
- Numbness
- Paralysis
- Dizziness
- Tremors
- Seizures

HEMATOLOGIC

- Anemia
- Bruise easily

ENDOCRINE

- Diabetes
- Excessive thirst or hunger
- Excessive sweating
- Lack of sweating
- Heat or cold intolerance
- Thyroid problem
- Hair loss
- Dizzy when standing/rising quickly
- Excessive weight loss
- Excessive weight gain

URINARY

- Frequent urination
- Blood in urine
- Incontinence
- Painful urination
- Urinate more than once at night

GASTROINTESTINAL

- Belching
- Flatulence/gas
- Black or tarry stools
- Blood in stool
- Change in stool
- Colitis
- Constipation
- Diarrhea
- Distention
- Excessive hunger
- Heartburn
- Food intolerance
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Stomach pain
- Trouble swallowing
- Vomiting

PSYCHOLOGICAL

- Anxiety
- Depression
- Insomnia / hard to fall asleep
- Nervousness
- Poor memory / forget quickly
- Violent thoughts
- Suicidal ideas
- Tend to worry

MUSCLES & JOINTS

- Arthritis
- Tendonitis
- Bursitis
- Gout
- Trouble with/poor posture
- Chronic pain
- Pain with specific movement(s)
- Pain relieved with anti-inflammatory drugs (aspirin, ibuprofen, Vioxx, etc...)
- Pain, tenderness, or numbness in:
 - Neck
 - Shoulders
 - Arms
 - Elbows
 - Wrist/hands
 - Upper back
 - Lower back
 - Hips
 - Knees
 - Feet/ankles

FEMALE

- Bleeding between periods
- Decrease sexual interest
- Pain with intercourse
- Discharge
- Itching
- Sores
- Yeast infections
- Sexually Transmitted disease
- PMS
 - Breast tenderness
 - Cramping/bloating
 - Back Pain
 - Over-emotional
 - Tired/fatigue
 - Other pain
 - Other symptoms
- Age at first period _____
- Number of days in cycle _____
- Usual length of period _____
- Start of last menstrual period date _____

- Number of pregnancies _____
- Number of deliveries _____
- Complications with pregnancies _____

- Birth control method _____

MALE

- Prostate problems
- Loss of sexual interest
- Hernia
- Erection trouble
- Discharge
- Premature ejaculation
- Sexually transmitted disease
- Testicular lump/pain
- Itching/rashes

DIET HISTORY

How much do you drink each day (**8oz**): Water: _____ Juice: _____ Soda Diet: _____ Soda Regular: _____

Coffee: Regular: _____ Decaf: _____ Tea: Regular: _____ Tea Sweet : _____ Energy Drinks/Other: _____

List oils or fats that you use in cooking: _____

Do you frequently skip meals? Y N Are you on any special diet or nutrition program? Y N

Describe: _____

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.

What foods do you dislike? _____ What is/are your favorite food(s)? _____

Circle the foods you crave:

Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods

Spicy foods Sour foods Cereals Dairy Other individual _____

*Do you use: (circle) butter margarine shortening coconut oil

*Do you know what partially hydrogenated fats are? Y N _____ If yes, do you eat them? Y N

*Do you eat from fast food restaurants? Y N -- If yes, how often? _____

What do you usually eat for **breakfast**? _____

What do you usually eat for **lunch**? _____

What do you usually eat for **dinner**? _____

What do you usually eat for **snacks** (in between meals and/or before bed)? _____

What foods do you eat a lot of (at least once a day, every day)? _____

How many bowel movements do you have per day? _____

A Bit More ----

*Type of sport/activity/exercise routine you participate in: _____

*Hours you train/exercise average per week: _____ *Do you train by yourself or with others? (circle)

*Do you use a heart rate monitor? Y N *What type of shoes do you wear? (Name/Style) _____

* Do you wear orthotics/arch supports/or any other devices during the day or when you exercise?

*Have you progressed, regressed, or plateaued in the past year? (circle)

*How many injuries (minor included) or illnesses do you suffer from per year? _____

*If applicable: When & what is your next competition you hope to participate in, or which one do you wish to "peak" for?
