

Dr. Derik Sanders DC, LLC
604 Main Street
Marble Falls, Texas 78654
(830)333-9877
www.drderiksanders.com

Thank you for choosing Dr. Derik Sanders for your Chiropractic and Wellness needs. Our goal is to provide for your health needs through the use of modern chiropractic and natural health techniques. We look forward to serving you.

Our office is located at 604 Main St. in Marble Falls. **Parking is located in the rear of the building and is accessible via the alley.** Please use the walkway on the side of the building to enter through the front entrance.

Please arrive wearing comfortable, loose-fitting clothing and allow up to one hour for your initial appointment.

Attached you will find a "Patient History". Please print and complete it. This will allow us to focus your examination on the matters of maximum importance to you. Bring your history along with a method of payment to your initial exam. We accept cash, check, credit or debit card and Venmo or PayPal. **A 3.5% transaction fee will be added to all credit card charges. No fees added to debit, cash, check, Venmo or Pay Pal.**

An acknowledgment of our "Privacy Policies & Consents" is included at the end of the history. A complete version of these policies is either included as a separate file or is available on our website. Please review the complete document prior to signing the acknowledgement.

Please note: Dr. Sanders is **NOT** in network with any insurance companies. You are responsible for payment in full at the time of service. If your insurance company reimburses you for chiropractic care, we can provide a statement to you that you can submit directly to your insurance company. They will then reimburse you directly. We recommend checking with your provider directly to understand your policy and coverage.

MediCare Patients: Dr. Sanders is **NOT** in network with MediCare. You are responsible for payment in full at the time of service. On a monthly basis, Dr. Sanders's office will submit visits to MediCare. MediCare will then send you a partial reimbursement directly based on your individual coverage. This is explained in the *Advanced Beneficiary Notice* that will be provided at your initial visit.

If you have any questions prior to your appointment, please call, text or email info@drderiksanders.com.

Supporting your well being,

Dr. Derik Sanders & Shana Sanders

ADULT INTAKE FORM

Last Name _____ First Name _____

Street Address, City, State & Zip _____

Cell Phone _____ Email _____

DOB _____ AGE _____ Gender ___M / F___ Marital Status ___M ___S ___W ___D

Occupation _____ Partner's Name _____

Name & Ages of Children _____

Emergency Contact Name _____ Phone _____

How did you hear about our office/ Who may we thank for referring you? _____

OVERALL HEALTH & HISTORY

Height _____ ft _____ in _____ Current Weight _____ Weight 1 yr ago _____

What would you rate your current overall health? ____/10 What would you like your health to be? ____/10

Have you seen a chiropractor before? Y / N If "YES": Who/ Where/ Specific Technique/ How was the experience?

Health Goals

- ☐ Wellness Care
- ☐ Relief of Current Symptoms
- ☐ Address & Correct Underlying Health Problems
- ☐ Reach & Maintain Optimal Health
- ☐ Minimize/ Eliminate Activity Limitations

Current Healthcare Provider(s) _____

Health checks in the last year

- | | |
|--------------------------------------|--------------------------|
| ☐ Vision | General/ Sports Physical |
| ☐ Dental | Therapist/ Counselor |
| ☐ Hearing | Men's Health |
| ☐ Dermatology | Women's Health |

Please list all vaccines you have had in the past 10 years _____

Family Medical History (Cancer/ Heart Disease/ Diabetes/ Kidney Issues/ etc) _____

Hospitalizations/ Serious Illness/ Auto Accidents/ Falls in the past 5 years? _____

List ALL surgeries (including replacements, etc), and/ or injuries (breaks/ sprains/ etc) _____

Have you experienced significant stress/ loss in the past 5 years? Y / N If yes: _____

DIET & LIFESTYLE

Please list all allergies (food/ dairy/ gluten/ herbs/ medications) _____

Please list all medications & supplements _____

Do you smoke? **Y N** Do you drink alcohol? **Y N** Are you well hydrated? **Y N Unsure**

Do you sleep well? **Y N** Are your teeth healthy? **Y N** Are you mentally stressed? **Y N**

Is screen time a major part of your day? **Y N** Do you frequently sit for hours at a time? **Y N**

Do you mainly eat nutritious, home-cooked meals with fresh ingredients? **Y N Unsure**

Do you crave sweets and regularly eat sugary foods? **Y N** So you use artificial sweeteners? **Y N**

Do you exercise regularly? **Y N Type?** _____

Do you play any sports? **Y N Type?** _____

Do you use orthotics, shoe lift, back brace, other support? **Y N Type?** _____

FEMALES ONLY

Have you been pregnant? Y / N Number of Pregnancies ____ Number of Live Births ____

PRIMARY CONCERN

What is your primary concern today? _____

Severity (1 lowest - 10 highest) ____/10 % of time noticed ____% Began _____

Event _____

Sensation (circle all that apply)

Sharp Burning Dull Ache Sore Stiff Spasm Numb

Moves to _____ Previous Episodes? Y / N If YES, When? _____

Progression - Getting Worse Getting Better Not Changing

Worse When - Sit Stand Walk Lift Exercise Other _____

Improves With - Rest Lying Down Massage Heat Cold Meds Other _____

Have you seen other providers for this? Y / N Who? _____

Additional Information / Anything you would like to add? _____

Signature _____ Date _____

SYMPTOMS & CONDITIONS

Please check the corresponding boxes for each symptom or condition you have experienced - including past and present.

PAST PRESENT

PAST PRESENT

Asthma
Appendicitis
Anemia
Arthritis
Allergies
Cancer
Diabetes
Eczema
Epilepsy

Heart Disease
Infertility
Mental Disorder
Abuse
Auto Accident
Head Trauma
Concussion
Sports Injury
Breaks/ Sprains

Excessive Crying
Ear & Sinus Infections
Allergies/ Congestion
Immune Deficiency
Headaches/ Migraines
Vertigo & Dizziness
Sore Throat/ Strep
Swollen Tonsils
Vision or Hearing Issues
Low Energy/ Fatigue
Difficulty Sleeping
Numbness/ Tingling
in Arms to Hands

Seizures
Sensory/ Spectrum
ADD/ ADHD
Focus/ Memory Issues
Anxiety/ Stress
Balance & Coordination
Speech Issues
TMJ/ Jaw Pain
Stiff Neck/ Shoulders
Depression
High Blood Pressure
Poor Metabolism

Reflux/ GERD
Chronic Colds/ Cough
Asthma

Bronchitis/ Pneumonia
Functional Heart
Condition

Gallbladder Issues
Jaundice
Fever

Indigestion/ Heartburn
Stomach Pain
Blood Sugar Issues

Behavior Issues
Hyperactivity
Chronic Fatigue
Chronic Stress

Allergies/ Eczema
Skin Conditions/ Rash
Kidney Problems
Gas Pain/ Bloating

Constipation
Chron's, Colitis, IBS
Diarrhea
Bed-Wetting
Bladder/ Urination Issues
Cramps/ Menstrual Issues
Cysts/ Endometriosis
Infertility
Impotency
Hemorrhoids

Sciatica/ Radiating Pain
Lumbopelvic/ SI Joint Pain
Hamstring Tightness
Disc Degeneration
Leg Weakness & Cramps
Poor Circulation
Knee/ Ankle/ Foot Pain
Weak Ankles/ Arches
Lower Back Pain
Gluten & Casein Intolerance

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

Signature of Patient

Date

