RETURNING PATIENT UPDATE

Patient Name: _____ **DOB**:_____ **Date:** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): (_____)_____ (Work): (_____)_____ (Mobile): (_____)_____

Email: _____

Symptom / Chief Complaint:_____

When Did It Start? _____ How Did It Start? _____

If The Pain Radiates, Where? _____ Type Of Pain: __Dull __Ache __Sore __Stiff __Sharp __Stinging __Numb

How Often Do You Feel The Pain? ___Constant (76-100%) ____ Frequent (51-75%) ____ Occasional (26-50%) ___ Intermittent (0-25% Of The Time)

Activities That Increase Your Pain: __Sitting __Standing __Walking __Lifting __Changing Position __Computer __Driving __Exercise _____

_____

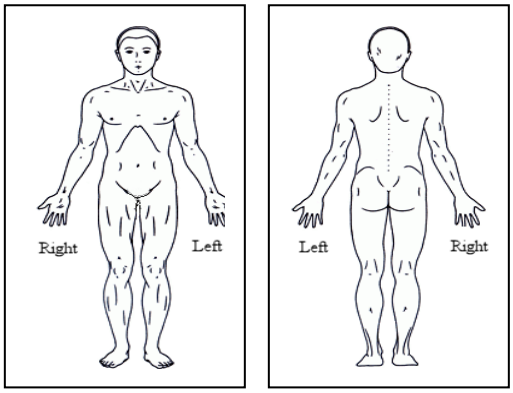
Things That Ease the Pain: __Rest __Cold __Heat __ Massage __ Medication _____

Additional Symptoms / Complaints: _____

_____

Pain Location

Indicate Pain Location On These Drawings



Pain Intensity

Indicate Pain Severity On These Scales

0 = No Pain
10 = Worst Pain

Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder/Arm Pain
0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Since You Were Last in, Have You Had Any of the Following?

- ☐ **Surgery** _____
- ☐ **Hospitalization** _____
- ☐ **Serious Illness** _____
- ☐ **Fracture/Dislocation** _____
- ☐ **Major Dental Work** _____
- ☐ **Any Changes with Medication/Supplements:** _____
- ☐ **Other:** _____

ACTIVITIES OF DAILY LIVING

For each activity, please circle the description that most closely describes how your pain or symptoms affect your life.

Activity	0	1	2	3	4
Mental Concentration	No difficulty	Slight difficulty	Moderate difficulty	A lot of difficulty	Cannot concentrate
Sleep	Perfect	Mildly disturbed	Moderately disturbed	Greatly disturbed	Totally disrupted
Sitting	Can sit as long as I like	Can only sit 1 hour	Can only sit 30 minutes	Can only sit 10 minutes	Unable to sit due to pain
Standing	No pain after several hours	Pain after several hours	Can only stand 1 hr	Can only stand ½ hr	Pain with any standing
Travel / Driving	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
Walking	No pain any distance	Pain after 1 mile	Pain after ½ mile	Pain after ¼ mile	Pain with all walking
Washing / Dressing	No restrictions and no pain	Mild pain, but no restrictions	Need to go slowly due to moderate pain	Need assistance due to pain or limitations	Require 100% assistance
Bending / Moving	No movement restrictions or pain	Mild pain, but no restrictions	Difficult to bend or change position	Bending or moving causes lingering pain	Unable to move more than a little
Lifting	No pain with heavy weight	Pain with heavy weight	Pain with moderate weight	Pain with lifting light weight	Pain with any lifting or bending
Work	No limitations and can do extra work	Can do usual work with difficulty	Can do 50% of usual work	Can do 25% of usual work	Cannot work
Social Life	Normal	Normal, but increases my pain	Energetic activities are limited	Stay home most of the time due to pain	Pain restricts me to my home
Recreation / Sports	Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

Name _____ Date _____ Add Numbers to Get Total Score _____

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 (print)	**Signature of Patient (Or Patient Parent/Representative)**	**Date**
	_____	_____
	Office Representative	**Date**