Jimmie D. Williams III, D.C., PA
Chiropractic Physician
Clinical Acupuncturist
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FOR OFFICE USE ONLY
BP: ______________________
DATE: ____________________

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

______________________ ______________________ __________
Last Name | First Name | Middle Initial

______________________ ______________________
Address (include apartment number if applicable) | City/State/Zip

______________________ ______________________ ______________________
Date of Birth (MM/DD/YYYY) | Social Security Number | Whom may we thank for referring you?

______________________ ______________________ ______________________
Home Phone | Cell Phone | E-Mail

______________________ ______________________
Emergency Contact Name | Emergency Contact Phone Number

Marital Status
○ Single
○ Married
○ Widowed
○ Separated

Number of Children:
____

Preferred Method of Contact
○ Cell ○ Home Phone ○ E-mail

Smoking Status (age 13+)
○ Never a smoker
○ Former smoker
○ Current Every Day Smoker
○ Occasional Smoker

Race
○ American Indian ○ Alaskan Native ○ Asian ○ Black or African American
○ Native Hawaiian ○ Other Pacific Islander ○ Other ○ White ○ Decline to answer

Ethnicity
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline to Specify

Preferred Language: ______________________

____
Your Occupation

____
Your Employer

____
Primary Care Provider's Name

____
Insurance Company's Name

Do you have any allergies to medication?

○ Yes ○ No

If yes, what? ______________
____
____
____

○ **Please send text reminders for my appointments.** My cell phone provider is:
○ AT&T ○ Sprint ○ T-Mobile ○ Verizon ○ Other ______________
Please send the reminder [○ one hour ○ two hours ○ four hours ○ a day] before my appointment.

Current Medications (please list medications and conditions):

Have you consulted a chiropractor before?
○ Yes ○ No

Primary Complaint
The primary symptom that prompted me to seek care today is:
____

And is the result of:
○ An accident or injury ○ Work
○ Auto accident ○ Unknown
○ A worsening long-term issue

Onset (when did you first notice your symptoms?) ____________________

Prior Interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Heat
○ Over the counter medications
○ Ice ○ Massage ○ Surgery
○ Stretching ○ Other ___________

____

Secondary Complaint
The secondary symptom that prompted me to seek care today is:
____

And is the result of:
○ An accident or injury ○ Work
○ Auto accident ○ Unknown
○ A worsening long-term issue

Onset (when did you first notice your symptoms?) ____________________

Prior Interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Heat
○ Over the counter medications
○ Ice ○ Massage ○ Surgery
○ Stretching ○ Other ___________

____

Additional Complaints
Additional symptoms that prompted me to seek care today are:
____

And is the result of:
○ An accident or injury ○ Work
○ Auto accident ○ Unknown
○ A worsening long-term issue

Onset (when did you first notice your symptoms?) ____________________

Prior Interventions (What have you done to relieve the symptoms?)
○ Prescription medication ○ Heat
○ Over the counter medications
○ Ice ○ Massage ○ Surgery
○ Stretching ○ Other ___________

____

My current condition interferes with my:
○ Work or Career ○ Recreational Activities ○ Household Responsibilities ○ Personal Relationships

What else should Dr. Williams know about your current condition? ____

____

Review of Systems: Chiropractic care focuses on the integrity of your nervous system which controls and regulates your entire body. Please darken the circle beside any condition you have **HAD** or currently **HAVE**.

Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Osteoporosis	○ ○ Arthritis	○ ○ Scoliosis	○ ○ Neck Pain	○ ○ Back Pain	○ ○ Hip Disorders
○ ○ Knee Injuries	○ ○ Foot Pain	○ ○ Shoulder Pain	○ ○ Arm Pain	○ ○ TMJ Issues	○ ○ Poor Posture

Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Anxiety	○ ○ Depression	○ ○ Headache	○ ○ Dizziness	○ ○ Pins/Needles	○ ○ Numbness

Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ High Blood Pressure	○ ○ Low Blood Pressure	○ ○ High Cholesterol	○ ○ Poor Circulation	○ ○ Angina	○ ○ Excessive Bruising

Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Asthma	○ ○ Apnea	○ ○ Emphysema	○ ○ Hay Fever	○ ○ Shortness of breath	○ ○ Pneumonia

Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Anorexia	○ ○ Ulcer	○ ○ Bulimia	○ ○ Heartburn	○ ○ Constipation	○ ○ Diarrhea

Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Blurred Vision	○ ○ Ringing in Ears	○ ○ Hearing Loss	○ ○ Loss of smell	○ ○ Loss of taste	○ ○ Difficulty Swallowing

Psychological

Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Depression	○ ○ Psychiatric Diagnosis	○ ○ Suicidal Ideations	○ ○ Bipolar Disorder	○ ○ Schizophrenia

Skin

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Skin Cancer	○ ○ Psoriasis	○ ○ Eczema	○ ○ Acne	○ ○ Hair Loss	○ ○ Rash

Endocrine

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Thyroid Issues	○ ○ Immune Disorders	○ ○ Hypoglycemia	○ ○ Frequent Infection	○ ○ Swollen Glands	○ ○ Low Energy

Genitourinary

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Kidney Stones	○ ○ Infertility	○ ○ Bedwetting	○ ○ Prostate Issues	○ ○ Erectile Dysfunction	○ ○ PMS symptoms

Constitutional

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have
○ ○ Fainting	○ ○ Low Libido	○ ○ Poor Appetite	○ ○ Fatigue	○ ○ Sudden weight loss/gain	○ ○ Weakness

Past Personal, Family and Social History Please identify your past health history, including accidents, injuries, illnesses and treatments.

Illnesses

Check the illnesses you have HAD in the past or HAVE now.

HAD	*HAVE*	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken Pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart Disease
○	○	Hepatitis
○	○	HIV Positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic Fever
○	○	Scarlet Fever
○	○	STD
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid Fever
○	○	Ulcer
○	○	Other: _________

____

____

Injuries

Have you ever. . .

- ○ Had a fracture or broken bone?
- ○ Had a spine or nerve disorder?
- ○ Been knocked unconscious?
- ○ Been injured in an accident?
- ○ Used a crutch or other support?
- ○ Used a neck or back brace?

Social History

	Daily	*Weekly*	*How Much?*
Alcohol Use	○	○	______________________
Coffee Use	○	○	______________________
Tobacco Use	○	○	______________________
Exercising	○	○	______________________
Pain Relievers	○	○	______________________
Soft Drinks	○	○	______________________
Water Intake	○	○	______________________

Operations

Surgical interventions which may or may not have included hospitalization.

- ○ Appendix Removal
- ○ Breast Augmentation
- ○ Bypass Surgery
- ○ Cancer
- ○ Cosmetic Surgery
- ○ Eye Surgery
- ○ Hysterectomy
- ○ Joint Surgery
- ○ Pacemaker
- ○ Spine Surgery
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: ___________

____

____

____

Family History

Relative	*State of Health*	*Illness*	*Age/Age at Death*
Mother	○ Good ○ Poor ○Deceased	______________	______________
Father	○ Good ○ Poor ○Deceased	______________	______________
Sibling	○ Good ○ Poor ○Deceased	______________	______________
Sibling	○ Good ○ Poor ○Deceased	______________	______________
Sibling	○ Good ○ Poor ○Deceased	______________	______________

Social

Do you have any hobbies ○ No ○ Yes If yes, what?

____

How much sleep do you average a night? ____________ hours

What is your preferred sleeping position: ○ back ○ side ○ stomach

What is the type and approximate age of your mattress and pillow?

____

What is the major stressor in your life?

____

Describe your typical eating habits: ○ skip breakfast ○ two meals a day ○ three meals a day ○ snacking between meals

What type of exercise do you do? ○ Walking ○ Running ○ Cycling ○ Weight Lifting ○ Classes (Spin, Zumba, etc) ○ Swimming ○ Gym ○ Other: ____

How often are you able to exercise? _____________________________

What would be the most significant thing you can do to improve your health?

____

For women only: An x-ray may be hazardous to an unborn child. Is there a possibility that you may be pregnant?

○ YES ○ NO

Is there anything else that Dr. Williams should know prior to treating you?

Activities of Daily Living: How does this condition currently interfere with your life and ability to function?

	No Effect	*Mild Effect*	*Moderate Effect*	*Severe Effect*		*No Effect*	*Mild Effect*	*Moderate Effect*	*Severe Effect*
Sitting	○	○	○	○	Grocery Shopping	○	○	○	○
Exercising	○	○	○	○	Rising Out of a Chair	○	○	○	○
Standing	○	○	○	○	Household Chores	○	○	○	○
Walking	○	○	○	○	Lifting Objects	○	○	○	○
Laying Down	○	○	○	○	Reaching Overhead	○	○	○	○
Bending Over	○	○	○	○	Showering/Bathing	○	○	○	○
Climbing Stairs	○	○	○	○	Dressing Myself	○	○	○	○
Yard Work	○	○	○	○	Getting to Sleep	○	○	○	○
Driving a Car	○	○	○	○	Staying Asleep	○	○	○	○
Concentrating	○	○	○	○	Caring for Family	○	○	○	○

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials	
_______	I give Dr. Williams my consent to deliver the care that, in his professional judgement, can best help me in the restoration of my health. Dr. Williams provides adjustments or manual manipulations through gentle, hands on application of targeted movements to improve motion of the body's spinal column and extremities. I understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. I understand chiropractic is separate and a distinct healing art from medicine and does not proclaim to cure any named disease or entity and, like most health care procedures, the chiropractic adjustment carries with it some risks. I further understand that physical therapies may be performed by trained chiropractic assistants.
_______	I have received a copy of the Notice of Patient Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for the purposes of treatment, obtaining payment, including from involved third parties, and supporting the day-to-day health care operations of this office. I give my permission to use and disclose my health information for these purposes.
_______	I am aware that some or all my treatment may be performed in an open environment and some routine, ongoing care may be discussed within earshot of other patients. I may always request privacy when discussing my care with the doctor.
_______	I grant permission to be called, emailed or texted to confirm or reschedule an appointment. I grant permission to be contacted by Dr. Williams, the office staff and/or the billing staff and left a message on my preferred method of contact. I agree that I may be sent occasional cards, letters or emails as an extension of my care in this office.
_______	I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I can request a copy of the Practice's full financial policy at any time.
_______	In the event my account is turned over to collections for non-payment, I am responsible for all collection costs including, but not limited to, collections agency fees, attorney fees and court costs.
_______	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____   ______________________________

Patient (or Guardian's) Signature   Date (MM/DD/YYYY)