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Chiropractic Physician
Clinical Acupuncturist
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FOR OFFICE USE ONLY

BP: _____PULSE: _____

DATE: _____ IMPLANTS: Y N

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 Who Referred You To Our Practice?

_____ _____
Phone Number E-Mail

May we send a thank-you to the person who referred you? ○ YES ○ NO

_____ _____
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

May we contact you at work?
○ Yes ○ No

_____
Work Phone

_____
Primary Care Provider's Name

_____
Insurance Carrier

_____
Policy Number

_____
Insured's Name

Do you have any allergies to medication?

○ Yes ○ No

If yes, what? _____

_____

_____

_____

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	○ ○ Stroke
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 and to be sent occasional cards, letters, emails or health information to me 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.
_____	I understand that Dr. Williams' emergency/after-hours office service fee is $35. This is in addition to any other treatment charges. I understand my insurance may not cover this fee and, if they do not, it is my financial responsibility.

_____ _____

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