

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.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

Whom may we thank for referring you?

☐ No ☐ Yes

When?

If so, whom?

Age

Gender

☐ Male ☐ Female

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

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Smoking Status (age 13 and over)

☐ Never A Smoker ☐ Former Smoker
☐ Current Every Day Smoker ☐ Current Some Day Smoker
☐ Heavy Smoker ☐ Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status ☐ Married

☐ Single ☐ Divorced

☐ Widowed ☐ Separated

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

☐ Yes ☐ No

City

State/Province

ZIP/Postal Code

Preferred method of contact?

☐ Home Phone ☐ Cell Phone
☐ Work Phone ☐ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

☐ Self ☐ Spouse ☐ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury

☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication

☐ Over-the-counter drugs

☐ Homeopathic remedies

☐ Physical therapy

☐ Surgery

☐ Other _____

☐ Acupuncture

☐ Chiropractic

☐ Massage

☐ Ice

☐ Heat

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury

☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication

☐ Over-the-counter drugs

☐ Homeopathic remedies

☐ Physical therapy

☐ Surgery

☐ Other _____

☐ Acupuncture

☐ Chiropractic

☐ Massage

☐ Ice

☐ Heat

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

☐ An accident or injury

☐ Work ☐ Auto ☐ Other _____

☐ A worsening long-term problem

☐ An interest in: ☐ Wellness ☐ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication

☐ Over-the-counter drugs

☐ Homeopathic remedies

☐ Physical therapy

☐ Surgery

☐ Other _____

☐ Acupuncture

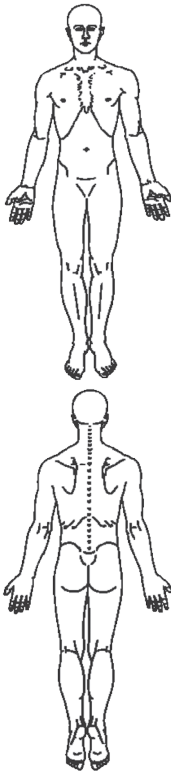
☐ Chiropractic

☐ Massage

☐ Ice

☐ Heat

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



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

2. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

3. 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 that you've Had or currently Have and initial to the right.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
<input type="radio"/> Osteoporosis	<input type="radio"/> Arthritis	<input type="radio"/> Scoliosis	<input type="radio"/> Neck pain	<input type="radio"/> Back problems	<input type="radio"/> Hip disorders	
<input type="radio"/> Knee injuries	<input type="radio"/> Foot/ankle pain	<input type="radio"/> Shoulder problems	<input type="radio"/> Elbow/wrist pain	<input type="radio"/> TMJ issues	<input type="radio"/> Poor posture	Initials _____

b. Neurological

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
<input type="radio"/> Anxiety	<input type="radio"/> Depression	<input type="radio"/> Headache	<input type="radio"/> Dizziness	<input type="radio"/> Pins and needles	<input type="radio"/> Numbness	
						Initials _____

c. Cardiovascular

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
<input type="radio"/> High blood pressure	<input type="radio"/> Low blood pressure	<input type="radio"/> High cholesterol	<input type="radio"/> Poor circulation	<input type="radio"/> Angina	<input type="radio"/> Excessive bruising	
						Initials _____

d. Respiratory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
<input type="radio"/> Asthma	<input type="radio"/> Apnea	<input type="radio"/> Emphysema	<input type="radio"/> Hay fever	<input type="radio"/> Shortness of breath	<input type="radio"/> Pneumonia	
						Initials _____

e. Digestive

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
<input type="radio"/> Anorexia/bulimia	<input type="radio"/> Ulcer	<input type="radio"/> Food sensitivities	<input type="radio"/> Heartburn	<input type="radio"/> Constipation	<input type="radio"/> Diarrhea	
						Initials _____

f. Sensory

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
<input type="radio"/> Blurred vision	<input type="radio"/> Ringing in ears	<input type="radio"/> Hearing loss	<input type="radio"/> Chronic ear infection	<input type="radio"/> Loss of smell	<input type="radio"/> Loss of taste	
						Initials _____

g. Skin

Had Have	Had Have	Had Have	Had Have	Had Have	Had Have	NONE
<input type="radio"/> Skin cancer	<input type="radio"/> Psoriasis	<input type="radio"/> Eczema	<input type="radio"/> Acne	<input type="radio"/> Hair loss	<input type="radio"/> Rash	
						Initials _____

Patient name _____

Patient Number
(office use only) _____

Doctor's Initials _____

Williams Chiropractic Clinic
Jeffrey A. Williams, D.C.

(Continued from previous page)

h. Endocrine

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Thyroid issues ☐ ☐ Immune disorders ☐ ☐ Hypoglycemia ☐ ☐ Frequent infection ☐ ☐ Swollen glands ☐ ☐ Low energy Initials _____

i. Genitourinary

Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Kidney stones ☐ ☐ Infertility ☐ ☐ Bedwetting ☐ ☐ Prostate issues ☐ ☐ Erectile dysfunction ☐ ☐ PMS symptoms Initials _____

j. Constitutional

Had Have Had Have Had Have Had Have Had Have Had Have NONE ☐
☐ ☐ Fainting ☐ ☐ Low libido ☐ ☐ Poor appetite ☐ ☐ Fatigue ☐ ☐ Sudden weight gain/loss (circle one) ☐ ☐ Weakness Initials _____

Patient name _____

Patient Number
(office use only)

☐ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL		4. Illnesses	5. Operations	6. Treatments																																																																																																																																																																																																																												
		Check the illnesses you have Had in the past or Have now.	Surgical interventions, which may or may not have included hospitalization.	Check the ones you've received in the Past or are receiving Currently .																																																																																																																																																																																																																												
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Consultation Notes

9. Family History

Some health issues are hereditary. Tell Dr. Williams about the health of your immediate family members.

FAMILY	Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
			Good	Poor			Natural	Illness
			<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
	Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
	_____	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

10. Are there any other hereditary health issues that you know about?

11. Social History

Tell Dr. Williams about your health habits and stress levels.

SOCIAL	Alcohol use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes <input type="radio"/> No
	Coffee use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes <input type="radio"/> No
	Tobacco use	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes <input type="radio"/> No
	Exercising	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes <input type="radio"/> No
	Pain relievers	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes <input type="radio"/> No
	Soft drinks	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
	Water intake	<input type="radio"/> Daily <input type="radio"/> Weekly	How much? _____		
	Hobbies: _____				

Doctor's Initials _____

Williams Chiropractic Clinic
Jeffrey A. Williams, D.C.

12. 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
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours

15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____

17. Describe your typical eating habits: ☐ Skip breakfast ☐ Two meals a day ☐ Three meals a day ☐ Snacking between meals

18. What would be the most significant thing that you could do to improve your health? _____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

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 instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called 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.

Initials _____ 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.

Initials _____ 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 name _____

Patient Number
(office use only)

Consultation Notes

Doctor's Initials _____

Williams Chiropractic Clinic
Jeffrey A. Williams, D.C.

Patient (or Guardian's) signature _____

Date (MM/DD/YYYY) _____