NEW PATIENT FORM

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr.

First Name:_____ Last Name:_____ ☐ M ☐ F

Address:_____ City:_____

Postal Code:_____ Age:_____ Birth Date: (D)_____/ (M)_____/ (Y)_____

Home Tel:_____ Cell:_____ Leave Message? ☐ Yes ☐ No

Occupation:_____ Email:_____

Preferred method of communication: Phone ☐ Email ☐

Emergency Contact:_____ Relationship: _____

Emergency Contact Phone #: (_____)_____ How did you hear about us? _____

Have you received chiropractic treatment before? ☐ Yes ☐ No Where? _____

Have you received physiotherapy treatment before? ☐ Yes ☐ No Where?_____

Have you received acupuncture before? ☐ Yes ☐ No Where?_____

Have you received massage therapy before? ☐ Yes ☐ No Where?_____

Medical Doctor's name: _____

Do you give consent to allow us to contact your medical doctor? ☐ Yes ☐ No

Do you have extended health coverage? ☐ Yes ☐ No

Would you like us to direct bill your insurance company? ☐ Yes ☐ No

Provider:_____ Name on Account (PRIMARY):_____

Policy #:_____ Member ID#:_____

CONSENT FOR COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

All personal information collected will remain safe and secured and will not be shared with anyone without patient permission.

The information may be collected via phone, personal interview, direct examination, transfer of medical information from other healthcare professionals, and third parties including insurance companies.

Personal information will only be seen by Williams Chiropractic and its staff.

By signing this form, I consent to the collection, use, and disclosure of my personal information.

_____ _____

Patient/Guardian Name (Print) Date

_____ _____

Patient/Guardian Signature Witness

Main Complaint: _____

When did this complaint start?_____
How did it start? _____

_____

Is this a work related injury? ☐ Yes ☐ No

Was this injury caused by a motor vehicle accident? ☐ Yes ☐ No

What is the pattern of this problem? ☐ Constant ☐ Intermittent

What level of pain has this complaint caused you? (0 = none, 10 = worst pain ever): _____
Has your pain traveled elsewhere? _____
What aggravates your condition the most? _____
What tends to relieve your pain? _____
Do you have any additional complaints? _____

Have you had previous treatment for your main complaint? ☐ Yes ☐ No

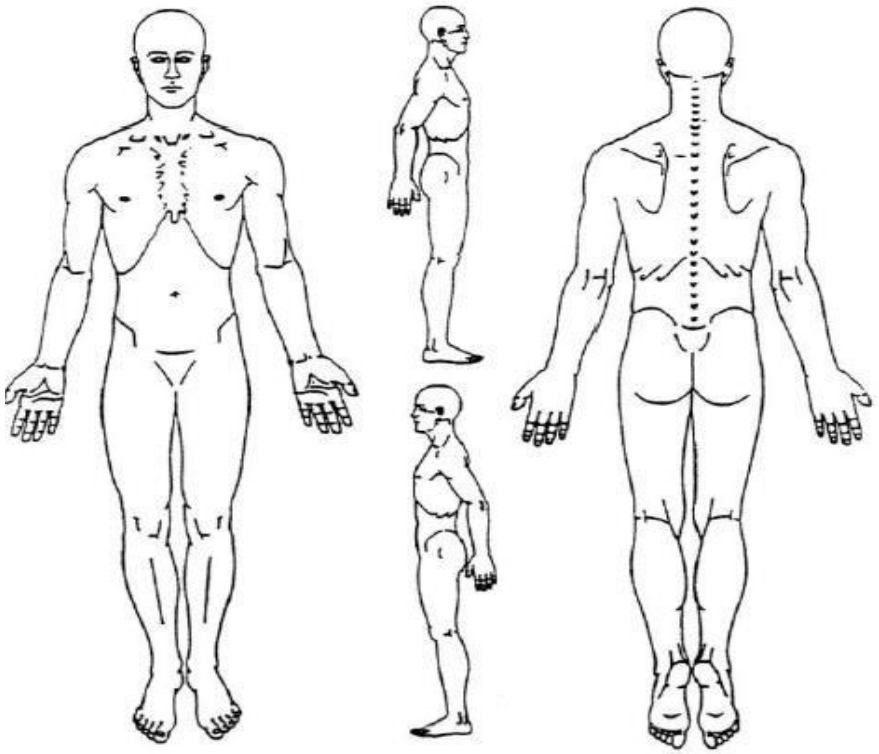
If yes, please describe what <u>did</u> and <u>did not</u> work for you: _____

_____

Which area of life does this problem affect? ☐ Work ☐ Family ☐ Sports ☐ Everyday Life

Explain:_____
What is your main goal when seeking treatment? _____

_____

Symptom Diagram: Please use the following chart to mark **"X"** in the areas that bother you.	

Personal Medical History:

Do you currently suffer from or have you suffered in the past from any of the following?
Mark "X" for any CURRENT or PAST issues.

⌋ Allergies	⌋ Eating disorder	⌋ Loss of strength	⌋ Ringing in the ears
⌋ Arthritis	⌋ Enlarged glands	⌋ Low bone density	⌋ Smoking
⌋ Bleeding disorder	⌋ Epilepsy	⌋ Menstrual issues	⌋ Sore/stiff low back
⌋ Blood in urine	⌋ Excess hunger or thirst	⌋ Motor Vehicle Accident	⌋ Sore/stiff mid back
⌋ Blurred or double vision	⌋ Fainting	⌋ Nausea	⌋ Sore/stiff neck
⌋ Bowel/bladder issues	⌋ Fever	⌋ Night sweats	⌋ Sore/stiff tailbone
⌋ Bruise easily	⌋ Fractures	⌋ Numbness or tingling	⌋ Spitting blood/phlegm
⌋ Cancer	⌋ Headaches	⌋ Painful ankle/foot	⌋ Stroke
⌋ Chest pain	⌋ Hearing problems	⌋ Painful arm/forearm	⌋ Surgery
⌋ Chronic cough	⌋ Heart attack / Angina	⌋ Painful hip	⌋ Swelling of ankles/joints
⌋ Circulatory problems	⌋ Hemorrhoids	⌋ Painful knee	⌋ Swollen/lump in breasts
⌋ Clumsiness	⌋ Hepatitis A/B/C	⌋ Painful shoulder	⌋ Thyroid issues
⌋ Concussions	⌋ High blood pressure	⌋ Painful wrist/hand	⌋ Tremors
⌋ Depression or anxiety	⌋ HIV/AIDS	⌋ Problems speaking	⌋ Varicose veins
⌋ Diabetes	⌋ Hot flashes	⌋ Problems swallowing	⌋ Vision problems
⌋ Difficulty breathing	⌋ Jaundice	⌋ Prostate trouble	⌋ Weak immune system
⌋ Digestion issues	⌋ Kidney issues	⌋ Psychological disorder	⌋ Weight loss/ gain
⌋ Dizziness	⌋ Loss of sleep	⌋ Rashes/itching	⌋ X-Ray, CT, MRI

Any other conditions that should be brought to your doctor's attention? _____

Family Medical History:

Please check if you or anyone in your family have any of the following:

☐ Cancer ___Myself ___Mother ___Father ___Sibling ___Other (specify): _____
☐ Heart Disease ___Myself ___Mother ___Father ___Sibling ___Other (specify): _____
☐ Stroke ___Myself ___Mother ___Father ___Sibling ___Other (specify): _____
☐ Diabetes ___Myself ___Mother ___Father ___Sibling ___Other (specify): _____
☐ High Cholesterol ___Myself ___Mother ___Father ___Sibling ___Other (specify): _____
☐ Hypertension ___Myself ___Mother ___Father ___Sibling ___Other (specify): _____
☐ Other Conditions: _____

WOMEN: Are you currently pregnant? ☐ Yes ☐ No # of Pregnancies:_____# of Children:_____
Are you using a birth control pill/patch? ☐ Yes ☐ No ☐ Previously How long (#years)? _____

Current Medication and Supplement List:

1._____ 4. _____
2._____ 5. _____
3._____ 6. _____