Dr. Thomas Williams
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"Life is better when you're WELLadjusted"

We are happy you have chosen us for your Chiropractic Wellness Care.
Please fill out these forms so Dr. Williams can establish a complete record of your personal health needs.

PLEASE PRINT

First Name:_____ M.I._____ Last Name:_____

Home Address: _____City_____Zip_____

Home Phone: _(___)_____ Cell: _(__ _)_____ Email: _____

Birth date:_____/_____/_____ Sex: □ Female □ Male Soc. Sec. Number: _____

Marital Status: □ Single □ Married □ Widow □ Divorced □ Partner How many children? _____

Employed: □Full-time □Part-time Student: □Full-time □Part-Time □Self-Employed □Unemployed □ Retired

Occupation:_____ Employer:_____ Work #:(_ __)_____

Employer address: _____

Name of Partner/Spouse: _____Partner/Spouse Birthdate:_____

Partner/Spouse's Employer:_____ Work #: (___)_____

Referred by: _____

Person to contact in emergency? _____ Phone: (_____)_____

Family Physician _____

STANDARD AUTHORIZATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
I hereby voluntarily authorize, WELLadjusted: a chiropractic wellness center, to release any and all medical information, until this authorization is further revoked, to:

_____Relationship:_____
_____Relationship:_____
_____Medical Doctor

I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Signature of Patient: _____ Date: _____

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Please mark the following conditions if they pertain to you.
Mark an "O" if it is a Past Condition or an "X" for a Present Condition.

_____ Auto Accidents
_____ (a) 0-1 years ago
_____ (b) 1-5 years ago
_____ (c) More than 5 yrs ago
_____ Other Accidents/ Falls
_____ Fractured Bones
_____ Knocked Unconscious
_____ Convulsions/ Epilepsy
_____ Diabetes
_____ Cancer
_____ Stroke
_____ High/low blood pressure
_____ Chest Pain
_____ Lung Problems
_____ Sinus Problems
_____ Difficult breathing
_____ Asthma
_____ Allergy
_____ Arthritis
_____ Gall Bladder trouble
_____ Kidney trouble
_____ Liver Trouble
_____ Ulcers
_____ Hemorrhoids
_____ Frequent urination
_____ Hearing Loss R / L
_____ Blurred /Double Vision R / L

_____ Headache
_____ Jaw Pain/ click (TMJ)
_____ Shoulder Pain R / L
_____ Neck pain/ stiffness
_____ Mid -Low back pain
_____ Hip Pain R / L
_____ Foot trouble R / L
_____ Impotence
_____ Prostate Problems
_____ Menopausal problems
_____ Menstrual problems / PMS
_____ Breast Lumps,soreness,discharge
_____ Venereal Disease
_____ Heartburn
_____ Belching/ Bloating
_____ Excessive Gas
_____ Diarrhea / Constipation
_____ Colon Trouble
_____ Digestive problems
_____ Skin Problems
_____ Itching
_____ Excessive Sweating
_____ Varicose Veins
_____ Loss of Balance
_____ Ear infections
_____ Ringing in ears R / L
_____ Mental/Emotion disorders

_____ Trouble sleeping
_____ Bedwetting
_____ Frequent colds/ Flu
_____ Back Curvature
_____ Head seems too heavy
_____ Anemia
_____ Bruise Easily
_____ Tremors
_____ Light headed upon rising
_____ Light bothers eyes
_____ Heart Problems
_____ Restless Leg Syndrome
_____ Fainting
_____ AIDS / HIV
_____ Dyslexia
_____ Learning Disability
_____ Stutter
_____ Loss of Memory
_____ Depressed
_____ Nervous
_____ Trouble concentrating
_____ Irritable
_____ Eating disorder
_____ Under Stress
_____ Mood changes
_____ Crave sweets/salt

Female Patients: Is there a chance you may be pregnant: □Yes □No □Unsure

FAMILY HEALTH HISTORY
Please check all that apply.

Mother:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health
If deceased—Age at death: _____

Father:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health
If deceased—Age at death: _____

Siblings:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health
If deceased—Age at death: _____

SOCIAL HISTORY. *Do you*:
Exercise regularly □ Yes □ No
Eat a balanced diet □ Yes □ No
Obtain sufficient rest □ Yes □ No
What is your typical breakfast? _____
What is your typical lunch? _____
What is your typical dinner? _____
What do you typically have for snacks? _____
Do you smoke? (packs/day): □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink coffee/tea? (cups/day): □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink alcohol? (drinks/day) : □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink soda? regular or diet and how much per day? _____
Do you typically find yourself feeling stressed? □Yes □No. Can you identify your stressors? □Always □Often □Rarely

MEDICAL HISTORY
Immunizations: (please circle all that apply)
1) Tetanus 2) Pertussis (whooping cough) 3) Diphtheria 4) German Measles 5) Measles 6) Mumps 7) Polio

Childhood Illnesses:
1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes 7) Cancer

List any serious childhood illnesses not recorded above:
_____ Age (_____)
_____ Age (_____)
_____ Age (_____)

List any birth defects: _____

Hospitalizations & Surgeries: If you have ever been hospitalized, list reason, and dates:
_____M/Y_____/_____
_____M/Y_____/_____
_____M/Y_____/_____

Adult Illnesses/ Injuries: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.
_____M/Y_____/_____
_____M/Y_____/_____

Do you have a pacemaker? □ Yes □ No

MEDICATIONS:
Medications: (include home remedies) List all medications that you are or have taken on a regular basis in the last 6 months.
A)_____ B)_____
C)_____

Medications to which you are allergic:
A)_____ B)_____
C)_____

I certify that the information on these forms is correct to the best of my knowledge. I will not hold Dr. Thomas Williams and any member of his staff responsible for any errors or omissions that I may have made in the completion of these forms.

Patient Signature: _____ Date: _____