WELLadjusted
a chiropractic wellness center

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

Thank you for choosing us for your Chiropractic Wellness care.
Please complete the following questionnaire to help us better serve your needs and understand your wellness goals.

First Name: _____ Last Name: _____

Why are you visiting us today? *(ie: pain, nutritional plans, physical training, etc)*_____
_____
_____

What are your current complaints?_____ ___
_____
Is this condition due to an: □ Automobile Accident □ Work Injury □ Other accident □ Unknown cause □ Illness

Date symptoms appeared: _____ Have you had these symptoms before? □ Yes □ No If yes, when? _____

Previous Chiropractic Care? □ Yes □ No Doctor's Name: _____ Were X-rays taken? □ Yes □ No
Have you seen another doctor for this condition? □ Physician □ Physical Therapist □ Other □ Not applicable
Doctor's Name: _____ Date consulted: _____ Were X-rays taken? □ Yes □ No

On a scale of 1 – 10, rate the importance for you to achieve the following:
1 = not important 10 = necessary

Get fit	1 2 3 4 5 6 7 8 9 10
Eat better	1 2 3 4 5 6 7 8 9 10
Reduce stress	1 2 3 4 5 6 7 8 9 10
Stop smoking	1 2 3 4 5 6 7 8 9 10
Reduce pain	1 2 3 4 5 6 7 8 9 10
Increase my mobility	1 2 3 4 5 6 7 8 9 10
Improve my posture	1 2 3 4 5 6 7 8 9 10
Improve my sleep	1 2 3 4 5 6 7 8 9 10
Learn about wellness	1 2 3 4 5 6 7 8 9 10
Learn about wellness products that are right for me	1 2 3 4 5 6 7 8 9 10
Other _____	1 2 3 4 5 6 7 8 9 10

Which of the above would you say is the most important goal for you to achieve and why?
_____
_____

Have you ever attempted to accomplish this goal in the past? □ Yes □ No

If yes, what happened and what prevented you from maintaining your results?

_____

_____

What are your goals for your care here at our wellness center? *(please check all that apply)*

□ **Relief Care**: Symptomatic relief of pain or discomfort.

□ **Corrective Care**: Correcting and relieving the cause of the problem as well as the symptoms.

□ **Comprehensive Care**: Correcting the body's malfunctions and enhancing the body's ability to heal, function, and remain healthy.

When do you hope to have these goals met?

_____

How do you see our clinic/Dr. Thomas Williams helping you meet these goals?

_____

_____

_____

Do you have any questions or comments?

_____

_____

_____

Do you wish to use your insurance or personal payment*? *(Please circle one: Insurance Personal Payment)*

***Did you know we offer discounts for patients who opt to not use their insurance for care? Ask us for more detail**

We appreciate referrals, were you referred by anyone today? □ Yes □ No

If yes, who referred you _____

I certify that the information on these forms is correct to the best of my knowledge. I will not hold Dr. Thomas Williar 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: _____

We thank you for your time and look forward to meeting you at your initial visit.
Keep in mind that this form is only a 'snap shot' of the information we will need to collect from you.
The doctor will meet with you at your initial consultation to obtain your full medical history as well as establis and compile a complete record of your own personal needs.

Thank you for choosing WELLadjusted for your wellness needs!