Welcome to Wilcox Family Chiropractic

Patient Information ___

Thank you for choosing Wilcox Family Chiropractic for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

(*Please print clearly*)

Name: ___
First Middle Initial Last

Address: ___ City: ___ State: ___ Zip: ___

Sex: ☐ Female ☐ Male Birthdate: ___ E-mail: ___

Home Phone : (___)___ Cell Phone: (___)___ Work Phone: (___)___

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ No Preference

☐ Married ☐ Widowed ☐ Single ☐ Children ___

Patient Employer/School: ___ Occupation: ___

Spouse or parent's name: ___ Employer: ___

Whom may we thank for referring you to us? ___

Person to contact in case of emergency: ___ Phone: (___)___

Responsible Party ___

Name of person responsible for this account: ___

Relationship to patient: ___ Phone: (___)___

Address: ___ City: ___ State: ___ Zip: ___

Medical Information ___

Dates of last physical: ___ Your Height: ___ Your Weight: ___

Do you use Tobacco products? ☐ Yes ☐No

Check one for Tobacco use: ☐Former user ☐ Never used ☐ Occasional use Type: ___

(Woman) Are you pregnant? ☐ Yes ☐No Nursing? ☐Yes ☐ No

List any types of surgeries which you have had and the dates which they occurred: ___

___

Please list any medications you are currently taking: ___

___

Allergies: ___

Is there any other condition you think the Doctor should know about? ___

___

Symptoms

Reason for visit: ____________________

When did you first notice the symptoms? ____________________

Is the condition getting progressively worse? ____________________

Where specifically is the problem(s) located? ____________________

Which activities are difficult to perform ? ☐ Sitting ☐Standing ☐Walking ☐Bending ☐Laying Down ☐Other

Type of Pain: ☐ Sharp ☐Dull ☐Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Rate the severity of your pain: (1= mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant of does it come and go? ____________________

What treatment have you received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other ____________________

Other Doctors seen for this condition: ____________________

Have you ever been under chiropractic care? ☐ Yes ☐ No Doctor's name: ____________________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to Wilcox Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Wilcox Family Chiropractic may us my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____________________ ____________________

Signature of Patient, Parent, Guardian or Personal Representative Date

____________________ ____________________

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

FOR OFFICE USE ONLY:____________________

Blood Pressure: __________ Pulse: __________ Primary Care Physician: ____________________