PATIENT INFORMATION

Date: _____ ☐ **Dr. Brady Williams** ☐ **Dr. Kimberly Patton**

Name: _____ Social Security #_____

Address: _____City:_____ State: _____ Zip:_____

E-mail address: _____ Home Phone: _____Cell Phone: _____

Age: _____ Birth Date: _____ Marital: M S W D

Appointment Reminder via (check preference): ☐ Phone ☐ Email ☐ Text ☐ None

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ DOB: _____ Employer: _____

Name of Nearest Relative: _____ City: _____ Phone: _____

How were you referred to our office? _____

Have you had previous chiropractic care? ☐ YES ☐ NO Date of last adjustment: _____

Reasons for previous chiropractic care: _____

Please check any and all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Medicare ☐ Auto Accident
☐ Medical Savings Account & Flex Plans ☐ Other

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at an annual rate of 16%.

INFORMED CONSENT: I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process. There are certain complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment. I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform or office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

REASON FOR CONSULTATION

Purpose of this appointment (describe symptoms): _____

_____

Date symptoms appeared or accident happened: _____

Have you ever had the same or similar symptoms? □ YES □ NO If yes, when and describe: _____

_____

What other treatments, if any, have you had for this condition? _____

_____

Is this condition a result of a work injury? □ YES □ NO

Is this condition a result of an auto accident? □ YES □ NO

Date accident happened: _____Days lost from work: _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now P = Previously

Headaches_____ Frequency_____		Loss of Balance	_____
Neck Pain	_____	Fainting	_____
Stiff Neck	_____	Loss of Smell	_____
Sleeping Problems	_____	Loss of Taste	_____
Back Pain	_____	Unusual Bowel Patterns	_____
Nervousness	_____	Feet Cold	_____
Tension	_____	Hands Cold	_____
Irritability	_____	Arthritis	_____
Chest Pains/Tightness	_____	Muscle Spasms	_____
Dizziness	_____	Frequent Colds	_____
Shoulder/Neck/Arm Pain	_____	Fever	_____
Numbness in Fingers	_____	Sinus Problems	_____
Numbness in Toes	_____	Diabetes	_____
High Blood Pressure	_____	Indigestion Problems	_____
Difficulty Urinating	_____	Joint Pain/Swelling	_____
Weakness in Extremities	_____	Menstrual Difficulties	_____
Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorder	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____		
Ulcers	_____		

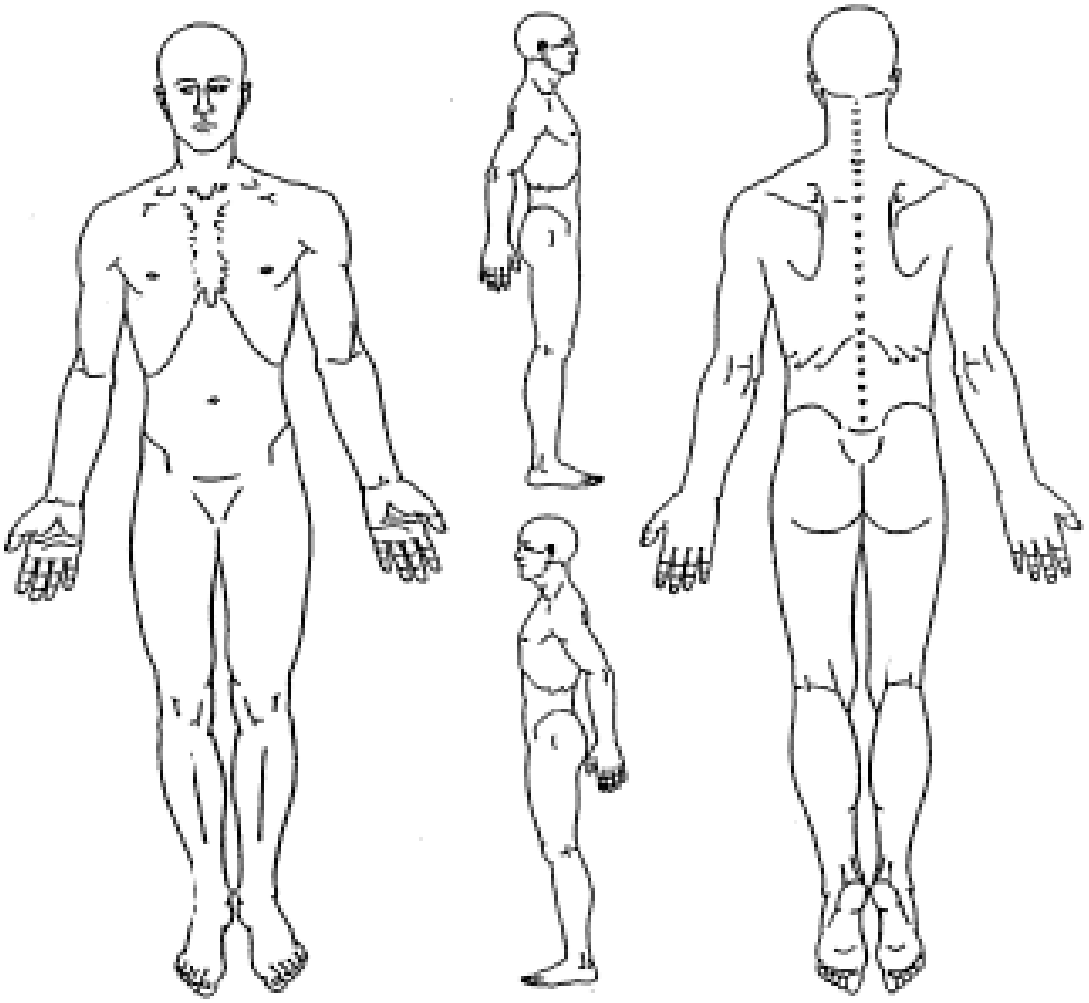
SYMPTOM DIAGRAM

NAME: _____ DATE: _____

Please read carefully.

Mark the areas on your body where you have symptoms, using the appropriate symbols below. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops, extending the arrow as far as the pain travels.

Ache >>>>> Numbness = = = = = Pins & Needles ° ° ° ° °
Burning x x x x x Stabbing ///// Throbbing ~ ~ ~ ~ ~



PAIN SCALE
Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 +10

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT MEDICAL HISTORY

Family Medical Doctor (include location):_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? □ YES □ NO

Date of last physical examination: _____

What surgeries have you had? (include dates) _____

Serious illness (include dates): _____

Have you been treated for any health conditions by a physician in the last year?

If yes, describe: _____

What medications or drugs are you taking? _____

_____

What vitamins or supplements are you taking? _____

_____

Are you allergic to any drugs or medications (if yes, please list)? _____

Childhood diseases: Measles _____ Mumps _____ Chicken Pox _____ other: _____

Unusual childhood disease: _____

Adult illnesses or conditions: _____

Hospitalizations: _____

Fractures: _____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:
OFTEN= "O" SOMETIMES= "S" NEVER= "N"

_____ Vigorous Exercise

_____ Moderate Exercise

_____ Alcohol Use

_____ Drug Use

_____ Tobacco Use

_____ Caffeine

_____ High Stress Activity

_____ Family Pressures

_____ Financial Pressures

_____ Other Mental Stresses

_____ Other (specify) _____

_____

_____

FAMILY HISTORY

Please review the below listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply.

CONDITION	FATHER Age[ ]	MOTHER Age [ ]	SPOUSE Age[ ]	BROTHER(S) Age [ ]Age [ ]	SISTERS Age [ ]Age[ ]	CHILDREN Age [ ] Age[ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause: _____

_____

I certify the information provided is accurate to the best of my knowledge:

Patient Name: _____

Patient Signature: _____

Date: _____