

Why This Form Is Important

As a wellness center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical, and psychological stresses that can accumulate and result in serious loss of health potential. Answering the following questions will give us a profile of the specific stresses that you face and allow us to better assess the challenges to your health potential and the functioning of your nervous system, which is the essence of chiropractic.

Reason for visit: Wellness Chiropractic Massage Power Plate Other _____ Date _____

DEMOGRAPHICS

First Name _____ Middle Name _____ Last Name _____

Nickname _____ SSN _____ Date of Birth _____ Male Female

Street Address _____ City / State / Zip _____

Home Phone _____ Primary Secondary Cellular Phone _____ Primary Secondary Alternate Phone _____ Primary Secondary

GUARDIANSHIP

Legal Guardian _____ Relationship to Patient _____

Street Address _____ City / State / Zip _____

Email Address _____

Home Phone _____ Primary Secondary Cellular Phone _____ Primary Secondary Alternate Phone _____ Primary Secondary

APPOINTMENT REMINDERS

If you would like an appointment reminder sent via text message please complete the following:

Service Provider (ie: Verizon/AT&T, etc.) _____ Cellular Number _____

How far in advance would you like your text message reminder: 15 minutes 30 minutes 45 minutes
 1 hour 2 hours 4 hours

MEDICAL INFORMATION

Pediatrician _____ Telephone _____ Date of Last Visit _____

EMERGENCY CONTACT

Emergency Contact _____ Relationship _____ Telephone _____

Wills Chiropractic

Minor Health Profile

CURRENT CONDITION(S)

Primary Concern _____ Date Episode Began _____

Condition Came On: Gradually Immediately Pre-Existing; Began _____

Condition is: Getting Better Getting Worse Staying Same

Describe Feeling: Dull Sharp Aching Shooting Spasm Throbbing
 Burning Numbing Tingling Other _____

Did condition begin with a specific injury/incident? Yes No If yes, please describe: _____

Have you seen a Doctor for this condition? Chiropractor Medical Other _____

Secondary Concern _____ Date Episode Began _____

Condition Came On: Gradually Immediately Pre-Existing; Began _____

Condition is: Getting Better Getting Worse Staying Same

Describe Feeling: Dull Sharp Aching Shooting Spasm Throbbing
 Burning Numbing Tingling Other _____

Did condition begin with a specific injury/incident? Yes No If yes, please describe: _____

Have you seen a Doctor for this condition? Chiropractor Medical Other _____

Additional Concern(s) _____ Date Episode Began _____

Condition Came On: Gradually Immediately Pre-Existing; Began _____

Condition is: Getting Better Getting Worse Staying Same

Describe Feeling: Dull Sharp Aching Shooting Spasm Throbbing
 Burning Numbing Tingling Other _____

Did condition begin with a specific injury/incident? Yes No If yes, please describe: _____

Have the patient seen a Doctor for this condition? Chiropractor Medical Other _____

SKILL DIFFICULTY

Please indicate current skills which are difficult to perform due to concerns on the previous page:

- | | | | | |
|-----------------------------------|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Holding | <input type="checkbox"/> Climbing | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Squatting | <input type="checkbox"/> Carrying | <input type="checkbox"/> Walking | <input type="checkbox"/> Loss of concentration |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Sitting | <input type="checkbox"/> Pulling | <input type="checkbox"/> Sports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tasting | <input type="checkbox"/> Reclining | <input type="checkbox"/> Pushing | <input type="checkbox"/> Exercising | |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Standing | <input type="checkbox"/> Reaching | <input type="checkbox"/> Driving | |
| <input type="checkbox"/> Smelling | <input type="checkbox"/> Leaning | <input type="checkbox"/> Pinching | <input type="checkbox"/> Riding in car | |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Bending | <input type="checkbox"/> Grasping | <input type="checkbox"/> Using the toilet | |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Twisting | <input type="checkbox"/> Writing | <input type="checkbox"/> Tactile feeling | |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Typing | <input type="checkbox"/> Restful Sleeping | |

PREVIOUS SYMPTOMS

Please indicate any symptoms experienced in the past six (6) months.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Irritability | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Lights sensitivity | <input type="checkbox"/> Tension | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Back pain/stiffness | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fever | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Other _____ |

ALLERGIES

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Environmental | <input type="checkbox"/> Non-Contributory | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Food reactions | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> No known allergies | <input type="checkbox"/> Pets | <input type="checkbox"/> Other _____ |

PAST MEDICAL HISTORY

- | | | | | |
|------------------------------------|--|--|--|--|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Chicken Pox - Age _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> Rubella - Age _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Whoop Cough - Age _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Mumps - Age _____ |

PAST SURGICAL HISTORY

- | | |
|--------------------------|--------------------|
| Surgical Procedure _____ | Surgery Date _____ |
| Surgical Procedure _____ | Surgery Date _____ |
| Surgical Procedure _____ | Surgery Date _____ |
| Surgical Procedure _____ | Surgery Date _____ |

ADDITIONAL CONCERNS

Please list any additional concerns you would like to address with the doctor: _____

ACCIDENT AND/OR INJURY HISTORY

Please indicate any injuries which were/are the result of auto, work or sports related injuries: _____

FAMILY HISTORY

Please select and indicate family member(s) affected by the conditions below (ie: Mother / Father / Sister / Brother / Grandparent):

- | | |
|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Osteoarthritis _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Renal Disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Stomach Ulcers _____ |
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Thyroid Disease _____ |

MEDICATIONS AND LIFESTYLE

Please list medications and/or nutritional supplements currently being taken and the reason for taking them: _____

Please list any unhealthy lifestyle habits (ie. caffeine, junk food, etc.): _____

Does the patient wear orthotic shoe inserts? Yes No How long have you worn your foot orthotics? _____

Has the patient had chiropractic care in the past? Yes No If yes, when was the last adjustment? _____

Were you satisfied with the previous care? Yes No If no, please explain _____

How did you hear about our office? _____

Who may we thank for referring you to our office? _____

Wills Chiropractic

Minor Health Profile

CONSENT AND AUTHORIZATION

Please read and initial each paragraph below. If you have questions regarding your consent and authorization, please ask a Wills Chiropractic staff member for assistance.

_____ I hereby authorize this office and its Doctors to administer care to my dependent as they deem necessary. I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

_____ I understand I am financially responsible, whether or not my insurance company pays, for all charges incurred by me. I hereby assign my major medical insurance benefits, private insurance and other health plans (excluding Medicare) to Wills Chiropractic. Any overpayment will be refunded.

Insurance Company _____ Policy # _____

Name of Policy Holder _____ Holder's Date of birth _____

_____ I authorize Wills Chiropractic to release any medical information and/or x-rays as needed to process claims for services rendered. I understand that this release is revocable at any time prior to the release of this information.

I have read, I understand, and I agree to comply with the above.

Guardian Name _____ Patient Name _____

Guardian Signature _____ Date _____