Willis ChiroMed

Confidential Patient Information (Please Print)

General Information Date _____

Name _____Social Security _____

Address _____City _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email Address _____

Age _____ Birth Date _____ Marital Status: M S W D How many children? _____ Ages? _____

Occupation _____ Employer _____

Work Address _____ Work Phone _____ If needed, may we contact you at work? Y N

Name of Insurance Company _____ Group/Policy # _____ Address _____

Insured's name, if different from patient _____ Social Security Number of Insured _____

Other Insurance Coverage _____

Name of Spouse _____ Occupation _____

Spouse's Employer _____ Work Phone _____ If needed, may we contact your spouse? Y N

Health History

Have you ever been under chiropractic care? Y N Doctor's name, date and reason for treatment_____

Have you been treated by any physician for any health condition in the past year? Y N If yes, describe_____

List all serious illnesses you've ever suffered from: None _____

List all serious illnesses in your family history: None _____

List all broken bones or joint dislocations you've suffered from: None _____

What operations have you had? Please give dates: None _____

Female: Could you be pregnant? Y N Date of last menstrual period _____ If pregnant, when is expected due date?_____

Social History

Do you smoke? Y N _____packs/day Do you drink alcohol? Y N If yes, how much _____ Do you use recreational drugs? Y N If yes, list _____

Occupational Duties _____ Hours worked/week _____ Recreational Activities_____

Review of Systems

Have you ever been treated for or had any problems with any of the following body systems? If yes, please describe.

Integumentary System (skin, hair, nails, etc.) No _____

Skeletal System (bones and joints) No _____

Muscular System (muscles, tendons, etc.) No _____

Cardiovascular System (heart, arteries, veins, lymph, etc.) No _____

Respiratory System (lungs, etc.) No _____

Nervous System (brain, spinal cord, nerves) No _____

Digestive System (esophagus, stomach, liver, pancreas, intestines, etc.) No _____

Urinary System (kidney, bladder, etc.) No _____

Endocrine System (glands) No _____

Reproductive System (genitalia, testes, uterus, ovaries, etc.) No _____

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Purpose of this appointment (Chief Complaints)_____

_____

Have you ever had the same or similar condition? Y N If yes, when and describe_____

_____

Is your condition due to an injury (work, car, slip/fall, other)? Y N If yes, when and describe what happened_____

_____

Date your symptoms appeared _____ Is your condition getting better, worse or is it staying the same?_____

How often do you feel your symptoms? Constant (100%), Frequent (75%), Intermittent (50%), Occasional (25%), Rare (10%), Other _____

What makes your condition worse?_____

What makes your condition better?_____

What does your pain feel like? Circle all that apply: Dull, aching, burning, pulling, tight, pulsing, throbbing, stabbing, shooting, numb, tingling, other_____

How is this condition affecting your life (work, sleep, daily routine, etc.)?_____

What other doctors have you seen for this condition?_____

Do you have a family history of this condition? Y N If yes, describe _____

What do you believe is wrong with you?_____

What medications are you currently taking?_____

Additional information_____

Payment is expected at the time of visit.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Parent/Guardian Information

Name _____ Social Security Number _____

Address _____ City/State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

I hereby authorize Willis ChiroMed to treat my minor child. _____Date _____
Parent or Guardian Signature

Information taken by _____ Date _____

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