Delivering Hope
WILLS CHIROPRACTIC, LLC

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CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

_____ ○ Yes ○ No _____ _____
Today's Date (MM/DD/YY) Have you seen a Chiropractor before? When? Whom?

_____ _____ ○ Male ○ Female
Whom may we thank for referring you? Your Social Security Number Gender

_____ _____ _____ _____
First Name Middle Name Last Name Birth Date (MM/DD/YY)

Marital Status
_____ ○ Single ○Married ○Divorced
Address ○ Widowed ○ Separated

_____ _____ _____ _____
City State Zip/Postal Code Spouse's Name

_____ _____ _____
Email Address Home Phone Cell Phone

_____ _____ _____
Emergency Contact Phone Child Name and Age

_____ _____ _____
Your Occupation Child Name and Age Child Name and Age

_____ May we contact you at work?
Your Employer ○ Yes ○ No

_____ Preferred Method of Contact?
Address ○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

_____ _____ _____ _____
City State Zip/Postal Code Work Phone

_____ Who Carries this policy?
Primary Insurance Carrier ○ Self ○ Spouse ○ Parent

_____ _____ _____
Insured's First Name Middle Name Insured's Last Name

_____
Insured's Birth Date (MM/DD/YY)

The symptom(s) that have prompted me to seek care today include:_____

_____

And are the result of: ○ An accident or injury
○ Work ○ Auto ○ Other _____
○A worsening long-term problem
○An interest in: ○Wellness ○ Other _____

Onset(When did you first notice your symptoms?)
_____

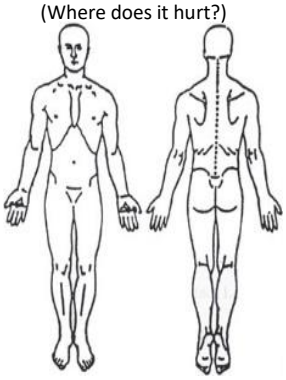
Intensity(How extreme are your symptoms?)
0-○-○-○-○-○-○-○-○-○-○-**10**
Absent Uncomfortable Agonizing

Duration(When did it start / how often to you feel it?)
○Constant ○ Comes and goes. How often?
_____

Quality of Symptoms
(What does it feel like?)
○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○Throbbing
○Stabbing
○ Other _____

_____

Location
(Where does it hurt?)



Radiation (Does it affect otherareas of your body?)

_____

Aggravates / Relieves (Whatmakes theproblem worse or better?)
What worsens theproblem?_____

_____
What lessens the problem?_____

_____

Prior Interventions (What have you done to relieve the symptoms?)
○Rx Meds ○ Surgery ○Ice
○ OTC drugs ○Acupuncture ○ Heat
○ Massage ○ Chiropractic ○ PT
○ Homeopathic Remedies ○Other

What else should we know? _____

How does your current condition interfere with your:
Work or career?_____

Recreational activities? _____

Household responsibilities? _____

Personal relationships? _____

Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

Musculoskeletal: ○ NONE

Had	Have	
○	○	Osteoporosis
○	○	Arthritis
○	○	Scoliosis
○	○	Neck Pain
○	○	Back Problems
○	○	Hip Disorders
○	○	Knee injuries
○	○	Foot/ankle pain
○	○	Shoulder problems
○	○	Elbow/wrist pain
○	○	TMJ issues
○	○	Poor posture

Sensory: ○ NONE

Had	Have	
○	○	Blurred vision
○	○	Ringing in ears
○	○	Hearing loss
○	○	Chronic ear infection
○	○	Loss of smell

Neurological: ○ NONE

Had	Have	
○	○	Anxiety
○	○	Depression
○	○	Headache
○	○	Dizziness
○	○	Pins and Needles
○	○	Numbness

Respiratory: ○ NONE

Had	Have	
○	○	Asthma
○	○	Apnea
○	○	Emphysema
○	○	Hay fever
○	○	Shortness of breath
○	○	Pneumonia

Integumentary: ○ NONE

Had	Have	
○	○	Skin cancer
○	○	Eczema
○	○	Hair loss

Cardiovascular: ○ NONE

Had	Have	
○	○	High Blood Pressure
○	○	Low Blood Pressure
○	○	High Cholesterol
○	○	Poor Circulation
○	○	Angina
○	○	Excessive bruising

Digestive: ○ NONE

Had	Have	
○	○	Anorexia/bulimia
○	○	Ulcer
○	○	Food Sensitivites
○	○	Heart burn
○	○	Constipation
○	○	Diarrhea

Had	Have	
○	○	Psoriasis
○	○	Acne
○	○	Rash

(continued from previous page)

Endocrine: ○ NONE

Had	Have	
○	○	Thyroid issues
○	○	Immune disorders
○	○	Hypoglycemia
○	○	Frequent infection
○	○	Swollen glands
○	○	Low energy

Genitourinary: ○ NONE

Had	Have	
○	○	Kidney stones
○	○	Infertility
○	○	Bedwetting
○	○	Prostate issues
○	○	Erectile dysfunction
○	○	PMS symptoms

Consitutional: ○ NONE

Had	Have	
○	○	Fainting
○	○	Low libido
○	○	Poor appetite
○	○	Fatigue
○	○	Sudden weight loss/gain
○	○	Weakness

Past, Personal, Family and Social History

Please identify your past health history, including accident, injuries, illnesses and treatments.

PERSONAL

Illnesses

Check those you have **Had** or **Have**

Had	Have	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart Disease
○	○	Hepatitis
○	○	HIV positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic fever
○	○	Scarlet fever
○	○	STD
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid fever
○	○	Ulcer

Operations

Surgical interventions which may or may not have included hospitalization

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____ _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____ _____ _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____ _____ _____

Injuries: Have you ever . . .

- ○ Had a fractured or broken bone
- ○ Had spine or nerve disorder
- ○ Been injured in an accident
- ○ Used neck or back bracing
- ○ Used a crutch
- ○ Been unconscious
- ○ Received a tattoo
- ○ Had a body piercing

Treatments

Past or are receiving **Currently**

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements _____ _____
○	○	Medications: (Rx or OTC) _____ _____

Family History

Some health issues are hereditary. Please tell us about the health of your immediate family members.

FAMILY

Relative Age (if living)	**State of Health** Good	Poor	**Illness**	**Age at death**	**Cause of death** Natural	Illness
Mother _____	○	○	_____	_____	○	○
Father _____	○	○	_____	_____	○	○
Sister 1 _____	○	○	_____	_____	○	○
Sister 2 _____	○	○	_____	_____	○	○
Brother 1_____	○	○	_____	_____	○	○
Brother 2_____	○	○	_____	_____	○	○

Are there any other hereditary health issues that you know about? _____

_____

Social History

Tell us about your health habi9ts and stress levels.

SOCIAL

					Yes	No
Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer	○	○
Coffee use	○ Daily	○ Weekly	How much? _____	Job stress	○	○
Tobacco use	○ Daily	○ Weekly	How much? _____	Financial peace	○	○
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated	○	○
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings	○	○
Soft drinks	○ Daily	○ Weekly	How much? _____	Recreation drugs	○	○
Water intake	○ Daily	○ Weekly	How much? _____			

Hobbies: _____

_____

Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising from chair	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering/ Bathing	○	○	○	○
Dressing mysel	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

What is the major stressor in your life? _____

How much sleep do you average per night? _____ hours **What is the age of your pillow?** _____

What is your preferred sleeping position? _____

Describe your typical eating habits:

- ○ Skip breakfast
- ○ 2 meals a day
- ○ 3 meals a day
- ○ Snacking between meals

What would be the most significant thing that you could do to improve your health? _____

_____

What additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials

_____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____

_____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concerns.

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date