Dr. Williams *Chiropractic Office*

(909) 592-2823

PATIENT INFORMATION

Legal First Name: _____ **MI:** _____ **Last Name:** _____

Street Address: _____ **Apartment:** _____

City: _____ **State:** _____ **Zip:** _____

Social Security: _____-_____-_____ **Marital Status: Single Married Divorced Spouse:** _____

Language: English _____ **Spanish** _____ **Indian** _____ **Japanese** ____ **Chinese** ____ **Korean** _____ **French** ____

German _____ **Russian** _____ **Other** _____

Race: African American _____ **Alaska Native** _____ **American Indian** _____ **Asian** _____ **Black** _____

Hispanic _____ **Latino** _____ **Native Hawaiian** _____ **Pacific Islander** _____ **Spanish** _____

White _____ **Decline To Answer** _____

Date Of Birth: _____ **Home Phone Number:** (_____) - _____-_____

Work Number: (_____) - _____-_____

Cell Phone Number: (_____) - _____-_____ **Cell Carrier:** _____

Contact Preference: Home Number: _____ **Work Number:** _____ **Cell Number:** _____ **E-Mail** _____

U.S.Postage: _____

E-Mail Home: _____ **E-Mail Work:** _____

Emergency Contact Person: _____ **Phone Number:** (_____) - _____-_-_____

Whom May We Thank For Referring You To Our Office? _____

Occupation: _____ **Employer:** _____

Employer's Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone Number:** (_____) - _____-_____

DATE: _____/_____/_____ ***PATIENT/INSURED/GUARDIAN SIGNATURE:*** _____

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DISCLOSURE & CONSENT
CHIROPRACTIC TREATMENT AND CHIROPRACTIC ADJUSTMENT(S)

TO THE PATIENT

You have a right as a patient to be informed about your condition, the recommended chiropractic treatment and the potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to treatment.

I (patient-guardian) request and consent to the performance of chiropractic procedures including but not limited to; orthopedic/neurological examination(s), diagnostic x-rays, various modes of physical therapy (heat packs, ice packs, therapeutic massage, transcutaneous nerve stimulation & ultra-sound) as well as chiropractic adjustments. The chiropractic treatment may be performed by the *Waites Earl Williams, Jr., D.C., QME.* Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for *Waites Earl Williams, Jr., D.C., QME.* I also acknowledge that I (patient-guardian) am financially responsible for all chiropractic services provided by *Waites Earl Williams, Jr., D.C., QME* and/or Dr. Williams *Chiropractic Office.*

I have had the opportunity to discuss with *Waites Earl Williams, Jr., D.C., QME,* my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment and the risks and benefits of alternative treatment including no treatment at all. I understand and I am informed that there are some risks to the performance of chiropractic procedures including but not limited to; orthopedic/neurological examination(s), diagnostic x-rays, various modes of physical therapy (heat packs, ice packs, therapeutic massage, transcutaneous nerve stimulation & ultra-sound) as well as chiropractic adjustments but not limited to:

PLEASE INITIAL ON EACH LINE BELOW

_____ **Fractures (broken bones)**	_____ **Increased Symptoms & Pain**
_____ **Spinal or Disc Injuries**	_____ **No Improvement of Symptoms/Pain**
_____ **Dislocations**	_____ **Stroke**
_____ **Sprains/Strains**	_____ **Condition(s) Not Revealed By Patient**

I do not expect *Waites Earl Williams, Jr., D.C., QME,* to be able to anticipate and explain all risks and complications. I wish to rely on *Waites Earl Williams, Jr., D.C., QME,* to exercise judgment during the course of my chiropractic treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the chiropractic treatment.

TO BE COMPLETED BY THE PATIENT

Date: ____/____/_____ _____ _____

Print Name | ***Signature Of Patient***

TO BE COMPLETED BY THE PATIENT'S REPRESENTATIVE

Date: ____/____/_____ _____ _____

Print Patient's Name | **Print Name Of Patient's Representative**

_____ _____

Signature Of Patient's Representative | **Relationship/Authority To Patient**

TO BE COMPLETED BY Dr. Williams *Chiropractic Office*

Date: ____/____/_____ _____ _____

Print - Witness To Patient's Signature | ***Signature – Witness To Patient's Signature***

Print Form

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Reset Form

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Department of Industrial Relations, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. Insurer Name and Address

2. Employer Name

3. Address No. and Street | City | Zip Code

4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes.)

5. Patient Name (first Name, middle initial , last name) | 6. Sex | 7. Date of Birth

8. Address No. and Street | City | Zip Code | 9.Phone Number

10. Occupation (Specific job title) | 11. Social Security Number | 12. Address No.& Street Where Inj. Occurred

City Where Injury Occ. | County | 13. Date and hour of injury or onset of illness

14. Date last worked | 15. Date and hour of 1st exam or treatment | 16. Have you or your office previously rendered treatment

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **Describe how the accident or exposure happened.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS**

19. **Objective Findings**

A. Physical Examination

B. X-ray and laboratory results (State if none or pending.)

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WORKERS' COMPENSATION CASE HISTORY

PLEASE PRINT

First Name: _____ **M.I.:** _____ **Last Name:** _____

Occupation And Specific Job Title: _____

_____

Employer Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone #:** (_____)- _____

Nature Of Business: _____

Do You Have An Attorney? _____ **If Yes, Please Give This Office Her/His Name, Address, Phone Number**

_____

_____

Date Of Accident/Injury: _____ **Time Of Accident/Injury:** _____ **A.M.** _____ **P.M.** _____

Date Last Worked: _____ **Are You Able To Perform Your Job Duties:** _____

Accident/Injury Occurred At: _____

Address: _____ **City:** _____

State: _____ **County:** _____

Were You Conscious? _____ **Did You Receive Medical Attention At The Accident/Injury Scene?** _____

Did You Go To A Medical Facility/Physician For Treatment After The Accident/Injury? _____

If Yes, Where: _____

_____

Where Do You Feel Pain? _____

_____

_____

Is Your Pain: Getting Worse _____ **Same** _____ **Improving** _____

Please Describe In Your Own Words How Your Accident/Injury Occurred

_____

_____

_____

_____

_____

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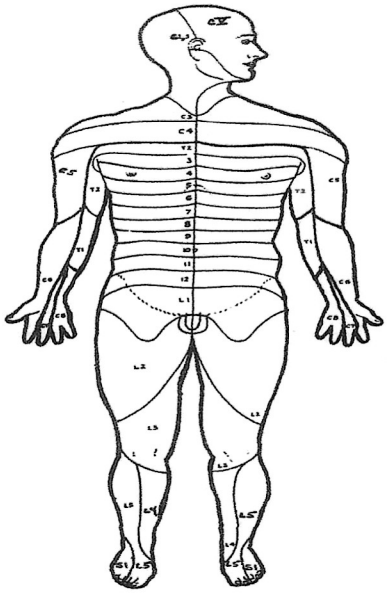
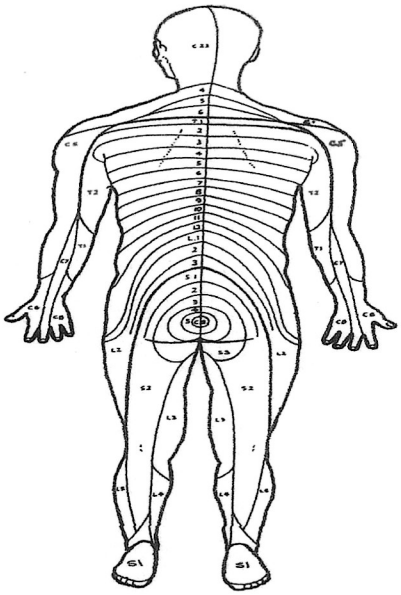
Please Mark Area(s) & Type of Pain On The Drawings Using The Letters Listed Below

A-Ache **N-Numbness P-Pain** **S-Soreness** **ST–Stiffness** **T-Tingling**





NOTES

_____

_____

_____

Dr. Williams *Chiropractic Office* Financial Policy

The State of California requires that before this office can provide any chiropractic services to you under the workers' compensation system, this chiropractic office must verify your work accident/injury with your employer and/or your employer's workers' compensation insurance company.

As a *Workers' Compensation* patient, your employer or your employer's workers' compensation insurance company will pay for all pre-approved chiropractic services rendered by this office.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Date _____/_____/_____ ***Signature*** _____

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PLEASE CHECK ALL PRESENT SYMPTOMS

DATE ____/____/_____ **NAME** _____

PRINT FIRST **PRINT MIDDLE** **PRINT LAST**

PLEASE CIRCLE RIGHT OR LEFT

HEAD

____ HEADACHES

____ SINUS

____ MIGRAINE HEADACHE

____ HEADACHE ON TOP OF HEAD

____ HEADACHE ON BACK OF HEAD

____ HEADACHE ON FOREHEAD

____ HEADACHE ON SIDE OF HEAD

____ HEAD FEELS HEAVY

____ LIGHT HEADEDNESS

____ DIZZINESS

____ RINGING IN EARS

NECK

____ PAIN IN NECK

____ NECK PAIN WITH MOVEMENT

____ MUSCLE SPASMS

SHOULDERS

____ PAIN IN RIGHT SHOULDER

____ PAIN IN LEFT SHOULDER

____ PAIN ACROSS SHOULDERS

____ UNABLE TO MOVE SHOULDER

____ MUSCLE SPASMS IN SHOULDER

ARMS & HANDS

____ PAIN IN UPPER RIGHT OR LEFT ARM

____ PAIN IN RIGHT OR LEFT ELBOW

____ PAIN IN RIGHT OR LEFT FOREARM

____ PAIN IN RIGHT OR LEFT HAND

____ NUMBNESS IN RIGHT OR LEFT EXTREMITY

MID - BACK

____ MID BACK PAIN

____ DULL PAIN

____ SHARP PAIN

ABDOMEN

____ STOMACH PAIN

____ GAS

____ CONSTIPATION

____ DIARRHEA

____ NAUSEA

____ HEMORRHOIDS

LOWER BACK

____ LOW BACK PAIN

____ LOW BACK PAIN UPON MOVEMENT

____ MUSCLE SPASMS

LEGS & FEET

____ PAIN IN UPPER RIGHT OR LEFT LEG

____ PAIN IN RIGHT OR LEFT KNEE

____ PAIN IN RIGHT OR LEFT LEG

____ PAIN IN RIGHT OR LEFT ANKLE

____ PAIN IN RIGHT OR LEFT FOOT

CHEST

____ CHEST PAIN

____ RADIATING CHEST PAIN

____ SHORTNESS OF BREATH

____ BREAST PAIN RIGHT OR LEFT

NOTES

_____

_____

_____