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***

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CASE HISTORY

PLEASE PRINT

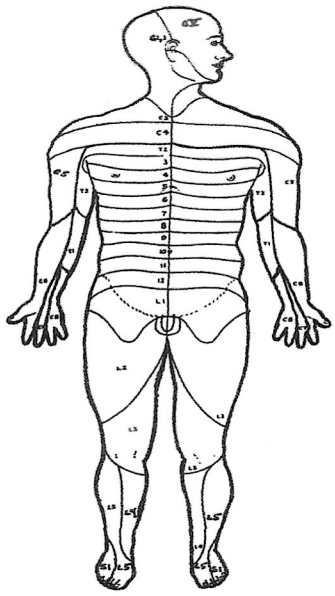
First Name **M.I.** **Last Name**

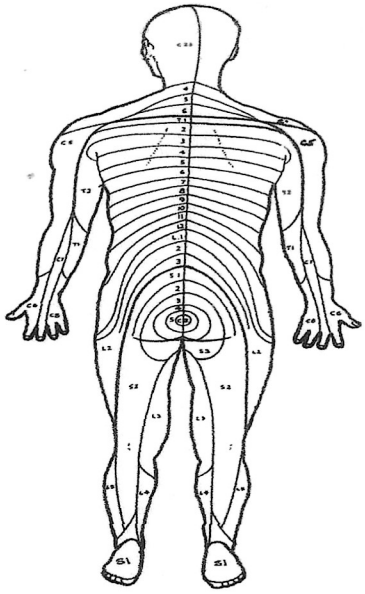
TYPE OF INJURY

Personal _____ **Sports** _____ **Motor Vehicle** _____ **Work Related** _____

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

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





PLEASE LIST THE REASON(S) YOU WOULD LIKE TO BE TREATED BY THIS OFFICE

1) _____

How Long Have You Had This Condition? **Day(s)** **Week(s)** **Month(s)** **Year(s)**

2) _____

How Long Have You Had This Condition? **Day(s)** **Week(s)** **Month(s)** **Year(s)**

Have You Had Any Spinal Surgical Procedures Such As Disc And/Or Vertebrae Fusions? Yes _____ **No** _____

If Yes When, Where, And Why? _____

_____

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Have You Had Any Surgical Procedures On Your Shoulder(s), Arms, Forearms, Wrist, Hands, Hip(s), Thighs, Legs And/Or Feet? Yes _____ No_____ If Yes When, Where, And Why? _____

_____

Have You Had Any Surgical Procedures Such As Brain, Heart, Liver, Lungs...etc? Yes _____ No _____ If Yes When, Where, And Why? _____

_____

In order for this office to properly serve you and help your condition, we need to know which of the following chiropractic treatment plans do you desire.

Acute Care aka Aspirin Care _____

I just want the pain to go away.

Rehabilitative Care aka Current Condition Care _____

I want the pain to go away and to correct the problem.

Preventative Care aka Wellness Care _____

I want to have regular chiropractic and spinal care.

Dr. Williams *Chiropractic Office* Financial Policy

I, the patient – guardian, understand Dr. Williams *Chiropractic Office* does not have a contract with my insurance company for chiropractic service(s) rendered therefore I, the patient - guardian, am financially responsible for all x-ray's, braces, orthopedic supports, supplements, vitamins as well as chiropractic service(s) rendered to and payment is due when chiropractic service(s) are rendered!

Date ____/____/____ *Patient's – Guardian's Signature* _____

DR. WILLIAMS CHIROPRACTIC OFFICE CONSULTATION NOTE(S):

_____

_____

_____

_____

_____

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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

CHEST

____ CHEST PAIN

____ RADIATING CHEST PAIN

____ SHORTNESS OF BREATH

____ BREAST PAIN RIGHT OR LEFT

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

NOTES

_____

_____

_____