WILLIAMSTON WELLNESS, PLLC
PATIENT INTAKE FORM

Today's Date ______________________

PATIENT INFORMATION:

Name____Age____Date of Birth_____/_____/_____

Address____City_______________________State_____Zip________

Home Phone ______________________ Cell Phone________________________Work Phone______________________

Email____**Ok to receive reminders via (circle)** text email both

Occupation____________________________________Employer or School Name________________________________

Gender (circle) M F T Marital Status (circle) S M D W P Spouse's Name_______________________________

# of Children __________Race & Ethnicity (required for Medicare /Medicaid)__________________________________

Current Student? ☐ Yes ☐ No If yes, ☐ Part-time or ☐ Full-Time Do you have a military ID? ☐ Yes ☐□ No

Emergency Contact Name____Phone______________________

Primary Care Doctor____________________________________Phone_____________________Last Seen____________

INSURANCE & PAYMENT INORMATION:

Please indicate all methods of payment: ☐ Insurance ☐ Cash ☐ Health Savings Account (HSA)

Primary Health Insurance Company Name____

ID/Policy #_______________________________ Group ____________________ Phone#__________________________

Policy Holder's Name___________________________________ SSN_________________ Birthdate _____/____/_____

Secondary/Supplemental Health Insurance Company Name____

ID/Policy #_______________________________ Group ____________________ Phone#__________________________

Policy Holder's Name___________________________________ SSN_________________ Birthdate _____/____/_____

GOALS/REASON FOR VISIT:

Please tell us what your goals & expectations are for your care at Williamston Wellness___________________________

____

How did you hear of us? If by referral, please list name____

What is the main reason for your visit?____

Are you here due to any injury? ☐Yes ☐ No If yes, when did the injury happen?______________________________

Please describe what happened ____

Is this a work or auto related injury? ☐ Work ☐ Auto If yes, has it been reported? ☐ Yes ☐ No

If you are here due to a work or auto accident, please ask receptionist for the proper paperwork. Thank you.

MEDICATIONS/SUPPLEMENTS:
List all Medications and Supplements you are currently taking including what it is for and how long you've been taking it.

____

____

____

____

INJURIES/SURGICAL PROCEDURES:
List all Surgical Procedures, injuries and Auto Accidents and year occurred.

____

____

Past Chiro Care? ☐ Yes ☐ No For what?____

Office/Chiro Name ______________________________Last seen__________Good Results? ☐ Yes ☐ No

Past Physical Therapy? ☐ Yes ☐ No For What? ____

Office/Doctor Name______________________________Last Seen__________Good Results? ☐ Yes ☐ No

When were your last x-rays taken and by whom?____

PREGNANCY HISTORY:

Are you pregnant? ☐ Yes ☐No ☐Maybe If yes, when are you due?__________Any complications? ☐Yes ☐ No

#of previous pregnancies__________ # of live births______________

If you are pregnant please ask the receptionist for the Prenatal Consent Form. Thank you.

ACTIVITIES OF DAILY LIVING:

1. Type of mattress (foam, coil, water etc..)___________________________________How old?__________
2. Type of pillow? ☐Foam ☐Feather ☐Other ________________ How many? ______How old? __________
3. Sleeping position? ☐Side ☐Stomach ☐ Back ☐ Combination 4. Do you sit on your wallet? ☐ Yes ☐ No
5. Define your stress level (use 1-10 scale, 10 being the most stressful).__________ at work __________at home
6. Do you have current pain with any of the following (mark all that apply):

☐ Dressing ☐ Stairs ☐ Lifting ☐ Standing ☐ Doing Dishes ☐ Getting Out Of Bed
☐ Walking ☐ Riding ☐ Working ☐ Bending ☐ Energy Increases ☐ Reaching ☐Sit to Stand
☐ Sleeping ☐ Driving ☐Exercising ☐ Sitting ☐ Other________________________________

Type of pain ☐ Dull ☐ Aching ☐ Sharp ☐ Shooting ☐ Burning ☐ Throbbing
☐ Nagging ☐Burning ☐ Aching ☐ Cramping ☐ Stiffness ☐ Deep

EXERCISE HABITS:
☐None
☐Mild____________________
☐Moderate_________________
☐Heavy___________________
Frequency______# Minutes/week

WORK HABITS:
☐Sitting (computer/phone)
☐Sitting (driving)
☐On feet all day
☐Light Labor (lifting/bending)
☐Heavy Labor (lifting/bending)

OTHER HABITS:
☐Tobacco Use __# packs/week
Since what age __________
☐ Alcohol ___# drinks/week
☐Drinks Soda ___# drinks/day
☐Drinks Caffeine ___#drinks/day

SYSTEMS REVIEW- Please mark any symptom the patient has had in the past 6 months

Genito-Urinary

☐ Back pain ☐ Blood in Urine ☐ Cloudy Urine ☐ Discolored urine ☐ Excessive urination
☐ Impotence ☐ Incontinence ☐ Kidney Stones ☐ Painful urination ☐ Prostate Problems ☐ STD

Nervous System

☐ Confusion/Forgetfulness ☐ Fainting ☐ Convulsions ☐ Depression ☐ Headaches ☐ Tingling ☐ Vertigo
☐ Numbness/Paralysis ☐ Trembling ☐ Muscle spasms ☐ Seizures ☐ Weak Grip ☐ Difficulty of speech

Eyes/Ears/Nose/Throat

☐ Lack of smell ☐ Earache/infection ☐ Ear Ringing/noises ☐ Ear Pain ☐ Eye Strain ☐ Sores/ulcers
☐ Nose Bleeds ☐ Trouble swallowing ☐ Sinusitis/hay fever ☐ Tonsillitis ☐ Sore Throats ☐ Hoarseness
☐ Speech difficulty ☐ Visual Disturbances ☐ Pain behind eyes ☐ Enlarged thyroid/lump in throat

Gastro-Intestinal

☐ Belching/Gas (excessive) ☐ Nausea ☐ Constipation ☐ Excessive Thirst ☐ Diarrhea
☐ Heartburn/acid reflux ☐ Ulcer ☐ Abdominal Pain ☐ Excessive Hunger ☐ Liver disease
☐ Gallbladder Problems ☐ Vomiting ☐ Bloody or Black Stool ☐ Weight Gain/Loss (+/-10lbs) ☐ Colitis

Cardio-Vascular

☐ Heart attack ☐ Heart disease ☐ High BP ☐ Coughing Blood ☐ Coughing Phlegm
☐ Rapid heart rate ☐ Persistent Cough ☐ Slow Heart Rate ☐ Irregular Heart Rate ☐ Pain over heart
☐ Lung Problems ☐ Difficulty breathing ☐ Chest pain ☐ Varicose Veins ☐ Asthma/wheezing
☐ Poor Circulation ☐ High Cholesterol ☐ Swelling ankles ☐ Blood Clot ☐ Bleeding Disorder

Musculoskeletal

☐ Back pain ☐ Hip pain ☐ Foot/Ankle pain ☐ Muscle pain ☐ Joint swelling ☐ Dislocated joint
☐ Neck pain ☐ Low back pain ☐ Wrist/hand pain ☐ Muscle weakness ☐ Joint stiffness ☐ Osteoporosis
☐ Knee pain ☐ Shoulder pain ☐ Fractures ☐ Muscle cramps ☐ Joint pain ☐ Spine curvature
☐ Arm pain ☐ Leg pain ☐ Sprains/Strains ☐ Muscle twitching ☐ Hot joints ☐ MS

Skin/Hair

☐ Bruise Easily ☐ Sensitive Skin ☐ Dermatitis/Rash ☐ Hives ☐ Itching ☐ Eczema
☐ Sores /Boils ☐ Hair Changes ☐ Nail bed changes ☐ Dryness ☐ Allergies______________________

Women ONLY

☐ Birth Control ☐ Breast Implants ☐ Breast Pain ☐ Breast Changes ☐ Hormone Replacement
☐ Hot Flashes ☐ Irregular cycle ☐ Miscarriages ☐ Heavy Flow ☐ PMS/Painful Periods

FAMILY HEALTH HISTORY	**Myself**	**Mother**	**Father**	**Sibling**	**Grandparent**
Arthritis	☐	☐	☐	☐	☐
Autoimmune Disease *Type:*	☐	☐	☐	☐	☐
Cancer *Type:*	☐	☐	☐	☐	☐
Depression/Mental health	☐	☐	☐	☐	☐
Diabetes *Type:*	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐
Fibromyalgia	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Joint Degeneration	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Lung Disease/Asthma	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐
Osteoporosis/Osteopenia	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐

SYMPTOM SURVEY: Please list problems from most severe to least severe. Please be as specific as possible.

Symptom #1:____

Location of Pain:_______________________________Severity of Pain _______(scale of 1-10, 10 being the worst pain)

Progression: ☐ Same ☐ Better ☐Worse How often is the pain present? ☐Constant ☐ 50-75% ☐25-50% ☐ <25%

When did the problem begin?____________________What do you think caused it?__________________________

Pain is reduced with: ☐ Rest ☐ Ice ☐Heat ☐ Stretching ☐ Exercise ☐ Pain relievers ☐ Topical creams

Pain is worse with: ☐ Sitting ☐ Standing ☐ Walking ☐Bending ☐ Twisting ☐ Lifting ☐ ________________

Description of pain: ☐ Sharp ☐ Shooting ☐ Dull ☐ Achy ☐Burning ☐ Stiff ☐Stabbing ☐Throbbing ☐ Numb

Does your pain radiate? ☐ Yes ☐ No If yes, where?____

What time of day is your pain the worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ During Sleep ☐ ________________

Any prior treatment for this symptom? ☐ Medication ☐ PT ☐ Surgery ☐ Chiro ☐ _________Helpful? ☐ Yes ☐ No

Symptom #2:____

Location of Pain:_______________________________Severity of Pain _______(scale of 1-10, 10 being the worst pain)

Progression: ☐ Same ☐ Better ☐Worse How often is the pain present? ☐Constant ☐ 50-75% ☐25-50% ☐ <25%

When did the problem begin?____________________What do you think caused it?__________________________

Pain is reduced with: ☐ Rest ☐ Ice ☐Heat ☐ Stretching ☐ Exercise ☐ Pain relievers ☐ Topical creams

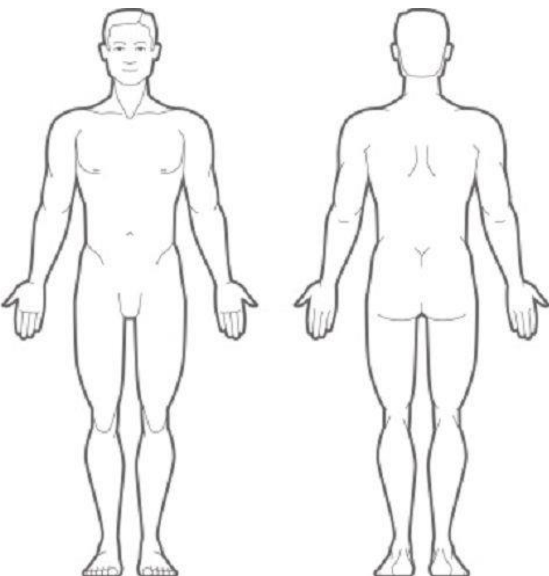
Pain is worse with: ☐ Sitting ☐ Standing ☐ Walking ☐Bending ☐ Twisting ☐ Lifting ☐ ________________

Description of pain: ☐ Sharp ☐ Shooting ☐ Dull ☐ Achy ☐Burning ☐ Stiff ☐Stabbing ☐Throbbing ☐ Numb

Does your pain radiate? ☐ Yes ☐ No If yes, where?____

What time of day is your pain the worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ During Sleep ☐ ________________

Any prior treatment for this symptom? ☐ Medication ☐ PT ☐ Surgery ☐ Chiro ☐ _________Helpful? ☐ Yes ☐ No



Please circle any areas of pain or discomfort on diagram and list any additional symptoms or comments:______________________________

____

____

____

____

____

____

____

____

____

WILLIAMSTON WELLNESS, PLLC 1235 E. Grand River Rd. Ste.1-A Williamston, MI 48895 Phone: (517) 655-4234 Fax: (517) 798-5676
Email: williamstonwellness@gmail.com Website: www.willamstonwellness.com

GENERAL/FINANCIAL CONSENT:

On behalf of yourself or any patient for whom you are the parent or legal guardian, you

- Certify that the information on this form is complete and accurate and that you will promptly notify our office of any changes.
- Assign to Williamston Wellness, any healthcare insurance or reimbursement benefits to which you are entitled to for the care provided by Williamston Wellness and authorize their payment directly to Williamston Wellness.
- Agree to be responsible for all charges owed to Williamston Wellness that are not covered by insurance and acknowledge that you are financially responsible for all charges regardless of any applicable insurance or benefit payments.
- If you are unable to keep a scheduled appointment, you agree to notify us no later than 24 hours before the scheduled time so that we may offer that appointment time to another patient. If proper notice is not given, a fee of $25 per half hour (based on scheduled appointment duration), may be billed starting with the 2nd no show/no call missed appointment.

Signature____ Date_________________________

INFORMED CONSENT:

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Signature____ Date_________________________

CONSENT TO RELEASE INFORMATION:

In the event that you ever wish to have a family member or friend come to our office and get a copy of your medical records, we ask that you sign below allowing them to do so. By signing below I hereby give my consent for Williamston Wellness, PLLC. to release my medical records to:

1.Name____ Relationship____________________

2. Name____ Relationship____________________

Patient Signature____ Date____________________

HIPPA ACKNOWLEDGEMENT & CONSENT:

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy of the Williamston Wellness Privacy Practices.

Patient Signature____ Date____________________