Welcome to Wills Chiropractic and thank you for applying as a patient to our office. We are a very unique team specializing in research-based spinal and postural rehabilitation. These methods enable our patients to achieve their optimal health where other systems may have failed. Due to the unique nature of our clinic, we may not accept you as a patient until we are certain that we know the cause of your condition and are able to establish an optimal rehab program especially for you to help you recover your health. Please understand that if we accept you as a patient, your health will need to be YOUR top priority as well as ours. At this point specific recommendations will be tailored to your individual needs.

Thank you again for applying as a patient to our clinic.

Patient Signature: ___________________________ Date: ________________
New Patient Application

Full Name: __________________________ Date of Birth: _______________  Gender (M) (f)

Home Street Address: __________________________ Home Phone: _______________

City, State, Zip: __________________________ Cell Phone: _______________

E-mail address: __________________________ Social Security #: _______________

Height: _______________ Weight: ________________ Marital Status: S  M  D  W

How were you referred to our office? ____________________________________________

Experience with Standard Chiropractic

Have you seen a chiropractor before?: [ ] yes [ ] no  who? __________________________

When? __________________________ Reason for visits: __________________________

Did your previous chiropractor take BEFORE and AFTER x-rays? [ ] yes [ ] no

Did your previous chiropractor tell you that poor posture can negatively affect your overall health [ ] yes [ ] no

Did your previous chiropractor make you aware of any of your poor postural habits? [ ] yes [ ] no

Are you aware of any poor posture habits in your spouse or children? [ ] yes [ ] no

Medical Doctor’s Seen:

Name: __________________________ Date of last visit: ________________ is this your primary care provider: [ ] yes [ ] no

Would you like us to forward our findings and recommendations to your physician? [ ] yes [ ] no

Name: __________________________ Date of last visit: ________________ is this your primary care provider: [ ] yes [ ] no

Would you like us to forward our findings and recommendations to your physician? [ ] yes [ ] no

Name: __________________________ Date of last visit: ________________ is this your primary care provider: [ ] yes [ ] no

Would you like us to forward our findings and recommendations to your physician? [ ] yes [ ] no

Previous Surgeries (all types) and dates: ____________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

What other testing / treatment have you tried to date for this present condition with location (facility) and dates of those tests and treatments: __________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Current over the counter medications: ____________________________________________

Current prescription medications: ____________________________________________
Social History and Lifestyle

Do you exercise: [ ] yes [ ] no  How often? 1X 2X 3X 4X 5X per week  other: ____________________________

What activities? ________________________________________________________________

Do you consider yourself to be: [ ] normal weight [ ] underweight [ ] overweight [ ] obese

Do you smoke? [ ] yes [ ] no  how often? ____________________________________________

Do you drink alcohol? [ ] yes [ ] no  how often? ______________________________________

Do you drink coffee? [ ] yes [ ] no  how often? ______________________________________

What supplements do you take (vitamins, minerals, herbs) __________________________________________

Family Health History

Have any of your biological family members ever been diagnosed with the following:

[ ] mental health disease  [ ] immune system problems  [ ] lung disease  [ ] thyroid  [ ] arthritis

[ ] neurological problems  [ ] high blood pressure  [ ] heart murmur  [ ] back pain  [ ] cancer  [ ] circulatory problems

[ ] kidney disease  [ ] heart disease  [ ] infectious disease  [ ] gall bladder  [ ] broken bones / fractures

[ ] liver disease  [ ] migraines  [ ] osteoporosis  [ ] scoliosis  [ ] seizures

[ ] autoimmune disease  [ ] digestive disorders  [ ] other: ____________________________

<table>
<thead>
<tr>
<th>Family History</th>
<th>Present Age</th>
<th>Age at Death</th>
<th>Medical problems / cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sister(s)</td>
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<td></td>
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<tr>
<td>Brother(s)</td>
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<td>Son / Daughter</td>
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Patient’s health conditions acceptable for Chiropractic Biophysics Corrective Care? [ ] yes [ ] no [ ] referred out

Doctor’s Signature: ________________________________  Date: ____________________
Please provide as much detail as possible for the reason for your visit:

Area of Complaint: ____________________________________________________________

What happened: ____________________________________________________________________________

When did this first occur? ____________________________________________________________________________

What makes it feel better?: ____________________________________________________________________________

Describe the pain:  ( ) sharp  ( ) dull  ( ) aching  ( ) burning  ( ) electric-like pain  ( ) radiating

Do you experience numbness / tingling or any radiating pain -where?: ____________________________

Frequency of pain:  ( ) constant  ( ) intermittent  ( ) occasional  ( ) not applicable

How bad is the pain:  none  1  2  3  4  5  6  7  8  9  10  severe

Does it feel better in the:  ( ) a.m.  ( ) p.m.  ( ) not applicable

How are your symptoms changing?  ( ) getting better  ( ) getting worse  ( ) staying the same

Does this pain restrict you from any daily activities? ____________________________________________

Area of Complaint: ____________________________________________________________

What happened: ____________________________________________________________________________

When did this first occur? ____________________________________________________________________________

What makes it feel better?: ____________________________________________________________________________

Describe the pain:  ( ) sharp  ( ) dull  ( ) aching  ( ) burning  ( ) electric-like pain  ( ) radiating

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How are your symptoms changing?  ( ) getting better  ( ) getting worse  ( ) staying the same

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What happened: ____________________________________________________________________________

When did this first occur? ____________________________________________________________________________

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How are your symptoms changing?  ( ) getting better  ( ) getting worse  ( ) staying the same

Does this pain restrict you from any daily activities? ____________________________________________
Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of disc condition, and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine neck adjustments may be vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at this Chiropractic office, a health and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and in particular your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care of provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

Patient Name:______________________________

Patient / Guardian Signature:_________________ Date:________________