Wills Chiropractic

New Patient Application

Welcome to Our Clinic!

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

Other Providers

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
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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	[ ] neurological problems	[ ] lung disease	[ ] thyroid	[ ] arthritis
[ ] immune system problems	[ ] heart murmur	[ ] back pain	[ ] cancer	[ ] circulatory problems
[ ] high blood pressure	[ ] heart disease	[ ] epilepsy	[ ] stroke	[ ] diabetes
[ ] kidney disease	[ ] migraine headaches	[ ] osteoporosis	[ ] scoliosis	[ ] seizures
[ ]liver disease	[ ] infectious disease	[ ] gall bladder	[ ] broken bones / fractures	
[ ]autoimmune disease	[ ] digestive disorders	[ ] other:_____		

Family History	Present Age	Age at Death	Medical problems / cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Sister(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____
Son / Daughter	_____	_____	_____

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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? _____

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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:_____