Dr. Thomas Williams
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859.523.1915 · www.welladjustedcenter.com
"Life is better when you're WELLadjusted"

We are happy you have chosen us for your Chiropractic Wellness Care.
Please fill out these forms so Dr. Williams can establish a complete record of your personal health needs.
PLEASE PRINT

ABOUT YOU

First Name:________________________________ M.I._____ Last Name:___________________________

Home Address: ____City_________________Zip______

Home Phone: ____________________ Cell: ____________________ Email: _______________________

Birth date:______/_______/_______ Sex: □ Female □ Male Soc. Sec. Number: _____________________

Marital Status: □ Single □ Married □ Widow □ Divorced □ Partner How many children? ___________

Employed: □Full-time □Part-time Student: □Full-time □Part-Time □Self-Employed □Unemployed □ Retired

Occupation:__________________________ Employer:_____________________ Work #:(___)__________

Employer address: ____

Name of Partner/Spouse: _____________________________________Partner/Spouse Birthdate:________

Partner/Spouse's Employer:____ Work #: (___)__________

Referred by: ____

Person to contact in emergency? _________________________________ Phone: (_____)_______________

Family Physician ____

STANDARD AUTHORIZATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
I hereby voluntarily authorize, WELLadjusted: a chiropractic wellness center, to release any and all medical information, until this authorization is further revoked, to:
____Relationship:____________
____Relationship:____________
____Medical Doctor
I understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Signature of Patient: ____ Date: __________________
You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Please mark the following conditions if they pertain to you.
Mark an "O" if it is a Past Condition or an "X" for a Present Condition.

_____ Auto Accidents	_____ Headache	_____ Trouble sleeping
_____ (a) 0-1 years ago	_____ Jaw Pain/ click (TMJ)	_____ Bedwetting
_____ (b) 1-5 years ago	_____ Shoulder Pain R / L	_____ Frequent colds/ Flu
_____ (c) More than 5 yrs ago	_____ Neck pain/ stiffness	_____ Back Curvature
_____ Other Accidents/ Falls	_____ Mid -Low back pain	_____ Head seems too heavy
_____ Fractured Bones	_____ Hip Pain R / L	_____ Anemia
_____ Knocked Unconscious	_____ Foot trouble R / L	_____ Bruise Easily
_____ Convulsions/ Epilepsy	_____ Impotence	_____ Tremors
_____ Diabetes	_____ Prostate Problems	_____ Light headed upon rising
_____ Cancer	_____ Menopausal problems	_____ Light bothers eyes
_____ Stroke	_____ Menstrual problems / PMS	_____ Heart Problems
_____ High or low blood pressure	_____ Breast Lumps,soreness,discharge	_____ Restless Leg Syndrome
_____ Chest Pain	_____ Venereal Disease	_____ Fainting
_____ Lung Problems	_____ Heartburn	_____ AIDS / HIV
_____ Sinus Problems	_____ Belching/ Bloating	_____ Dyslexia
_____ Difficult breathing	_____ Excessive Gas	_____ Learning Disability
_____ Asthma	_____ Diarrhea / Constipation	_____ Stutter
_____ Allergy	_____ Colon Trouble	_____ Loss of Memory
_____ Arthritis	_____ Digestive problems	_____ Depressed
_____ Gall Bladder trouble	_____ Skin Problems	_____ Nervous
_____ Kidney trouble	_____ Itching	_____ Trouble concentrating
_____ Liver Trouble	_____ Excessive Sweating	_____ Irritable
_____ Ulcers	_____ Varicose Veins	_____ Eating disorder
_____ Hemorrhoids	_____ Loss of Balance	_____ Under Stress
_____ Frequent urination	_____ Ear infections	_____ Mood changes
_____ Hearing Loss R / L	_____ Ringing in ears R / L	_____ Crave sweets/salt
_____ Blurred or Double Vision R / L	_____ Mental/Emotion disorders	

Female Patients: Is there a chance you may be pregnant: □Yes □No □Unsure

FAMILY HEALTH HISTORY
Please check all that apply.

Mother:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health
If deceased—Age at death: ___________

Father:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health
If deceased—Age at death: ___________

Siblings:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health
If deceased—Age at death: ___________

SOCIAL HISTORY. *Do you*:
Exercise regularly □ Yes □ No
Eat a balanced diet □ Yes □No
Obtain sufficient rest □ Yes □ No
What is your typical breakfast? ____________________
What is your typical lunch? ____________________
What is your typical dinner? ____________________
What do you typically have for snacks? ____________________
Do you smoke- (packs/day): □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink coffee/tea- (cups/day): □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink alcohol- (drinks/day) : □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink soda? - regular or diet and how much per day? ____________________
Do you typically find yourself feeling stressed? □Yes □No Can you identify your stressors? □Always □Often □Rarely

MEDICAL HISTORY
Immunizations: (please circle all that apply)
1) Tetanus 2) Pertussis (whooping cough) 3) Diphtheria 4) German Measles 5) Measles 6) Mumps 7) Polio

Childhood Illnesses:
1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes 7) Cancer

List any serious childhood illnesses not recorded above:
____________________ Age (_____)
____________________ Age (_____)
____________________ Age (_____)

List any birth defects: ____________________

Hospitalizations & Surgeries: If you have ever been hospitalized, list reason, and dates:
____________________M/Y_____/_____
____________________M/Y_____/_____
____________________M/Y_____/_____

Adult Illnesses/ Injuries: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.
____________________M/Y_____/_____
____________________M/Y_____/_____

Do you have a pacemaker? □ Yes □ No

MEDICATIONS:
Medications: (include home remedies) List all medications that you are or have taken on a regular basis in the last 6 months.
A)____________________
B)____________________
C)____________________

Medications to which you are allergic:
A)____________________
B)____________________
C)____________________

I certify that the information on these forms is correct to the best of my knowledge. I will not hold Dr. Thomas Williams and any member of his staff responsible for any errors or omissions that I may have made in the completion of these forms.

Patient Signature: ____________________ Date: ____________________