4455 Calder Avenue
Beaumont, Tx 77706

WILLIAMSON
CHIROPRACTIC

NEW PATIENT INTAKE FORM

Name: (First MI Last) _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____ **Date of birth**: _____/_____/_____

- Work
- Home
- Cell

Age: _____

Gender: Female Male

Occupation: _____ **Employer**: _____

Emergency Contact: _____ **Phone #**: _____

Relationship to Patient:

- Spouse
- Parent
- Child
- Other_____

Primary Care Physician: _____ **Phone #**:_____

Have you ever received chiropractic care before?

- Yes
- No

If yes, when & where? _____

How did you hear about Williamson Chiropractic?

Name: _____

- Family
- Friend
- Co-Worker
- Doctor
- Social Media
- Google/Online
- Other_____

Are you currently covered by Medicare/Medicaid: YES NO

Are you currently/have you ever served in the Armed Forces or as a Police Officer? YES NO

Email: _____

*We do not sell our email list.

- I would like to receive emails **regarding appointment reminders, office closures, holiday hours, promotions, discounts, health & wellness information, monthly newsletter, etc.**
- I would only like to receive emails **regarding appointment reminders, office closures and holiday hours.**

PATIENT HISTORY

Reason(s) for visiting today:

_____

When did this begin?

_____

What happened?

_____

Have you ever experienced this pain before?

- Yes
- No

Describe your pain:

- Tingling
- Numbness
- Stabbing
- Dull
- Stiffness
- Soreness
- Sharp
- Throbbing
- Burning
- Aching
- Other _____

Improves with:

- Ice
- Heat
- Stretching/Moving
- Medication _____
- Other _____

Worsens with:

- Sitting
- Standing
- Walking
- Sleeping
- Lifting/Overuse
- Other _____

Is the pain constant or does it come and go?

- Constant
- Comes and goes
- Other_____

Does it radiate?

- Yes
- No

Rate severity of pain:

- 1) no pain
- 2)
- 3)
- 4)
- 5)
- 6)
- 7)
- 8)
- 9)
- 10) worst pain imaginable

Previous Treatment:

- NONE
- Chiropractor
  _____
- Medical Doctor
  _____
- Physical Therapy
  _____
- ER/Urgent Care
  _____
- Orthopedic
  _____
- Other
  _____

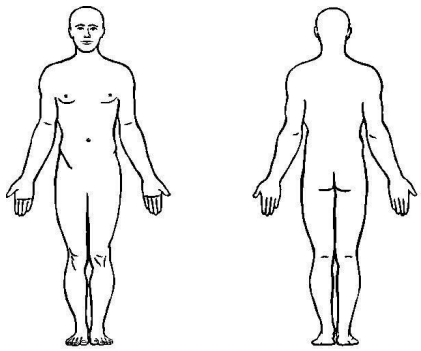
Previous Imaging:

- NONE
- X-Ray
- CT
- MRI
- Other

Have you ever, or are you currently experiencing:

- Headaches
- Migraines
- Neck pain
- Numbness/Tingling
- Shoulder pain
- Upper back pain/Stiffness
- Lower back pain
- Hip pain
- Other_____

FRONT **BACK**



<u>Please indicate location of pain on the pictures above.</u>

Please list all current medications:

_____
_____
_____
_____

Doctor's Notes

_____
_____
_____
_____
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_____
_____

PAST, FAMILY, & SOCIAL HISTORY

Have you **EVER** had any of the following?

Illnesses:
- o Asthma
- o Autoimmune Disorder _____
- o Blood Clots
- o Cancer _____
- o CVA/TIA (Stroke)
- o Diabetes
- o Migraines
- o Osteoporosis
- o Other_____

Injuries:
- o Back Injury
- o Broken Bones
- o Head Injury
- o Neck Injury
- o Falls
- o Other _____

Hospitalizations: (non surgical):
_____

Surgeries: (if yes, explain)
- o Cancer _____ _____
- o Shoulder R/L_____
- o Elbow/Forearm R/L_____
- o Wrist/Hand R/L_____
- o Hip R/L_____
- o Knee R/L_____
- o Ankle/Foot R/L_____
- o Neck _____ _____
- o Back_____ _____
- o Other_____ _____

Motor Vehicle Accidents:
- o _____ _____ _____

Doctor's Notes:
_____
_____
_____
_____
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_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

- o Unknown
- o Unremarkable (none)
- o Heart Disease
- o Cancer
- o Stroke
- o High Blood Pressure
- o Diabetes
- o Other _____

SOCIAL HISTORY

Marital Status:
- o Single
- o Married
- o Divorced
- o Other_____

Children:
- o None
- o 1
- o 2
- o 3
- o 4
- o Other_____

Student Status:
- o Full Time
- o Part Time
- o Non Student

Highest level of Education:
- o High School
- o College
- o Post Grad
- o Other_____

Employed:
- o Yes
- o No
- o Occupation_____

Smoking/Tobacco Use:
- o Every Day
- o Some Days
- o Former
- o Never

Alcohol Use:
- o Every Day
- o Weekly
- o Occasionally
- o Never

Caffeine Use:
- o Coffee
- o Tea
- o Soda
- o Energy Drinks
- o Never

Exercise Frequency:
- o Daily
- o 4-5 x/week
- o 2-3 x/week
- o Rarely
- o Never

Doctor's Notes: _____
_____

WILLIAMSON CHIROPRACTIC SERVICES, PLLC
Terms of Acceptance

Patient Name: _____ D.O.B: _____ Date: _____

Before Williamson Chiropractic begins any health care services, we require that you read the below information and sign this form stating that you fully understand the following statements. If you do not sign this form, Dr. Williamson reserves the right to refuse patient care.

AUTHORIZATION: By signing this form, you hereby authorize this office/provider to complete an examination and consultation on the above-mentioned patient.

ACKNOWLEDGEMENT OF ASSIGNED BENEFITS: By signing below, you have acknowledged that you are fully responsible for all services rendered.

ACKNOWLEDGEMENT OF NO-SHOW/ SAME DAY CANCELLATION FEE: By signing below, you also acknowledge that if you cancel on the same day as your scheduled appointment OR do not show up to a scheduled appointment and have made no attempt to cancel, you will be charged a $20.00 no show fee per patient booked.

ACKNOWLEDGEMENT OF CASH PRACTICE: By signing below, you have acknowledged that Williamson Chiropractic is considered a cash practice and does not file with insurance providers. We do not submit insurance claims regarding chiropractic care, nor do we communicate with insurance companies regarding any patients that may submit claims for care received at our office.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personal health information. There may be times where our office may need to contact you regarding office matters. By signing below, you have authorized this office for office related matters in the following manners: work phone, home phone, cell phone, e-mail, and regular mail. Messages may be left on an answering machine/voicemail, or with the person who answers you work-home-cell phone. Also, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), updated on September 23, 2013, this office is obliged to supply you with a copy of the office privacy policy and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below, you have acknowledged that you have been offered a copy of this document.

ACKNOLEDGMENT OF TREATMENT PLAN: By signing below, you have acknowledged that, if accepted for care, you may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.

ACKNOWLEDGEMENT: By signing below, you have acknowledged that you understand and agree with the policies and procedures outlined in this TERMS OF ACCEPTANCE form. By signing below, you acknowledge and certify that all information given to the office/provider in the INTAKE forms are true and accurate to the best of your knowledge.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian:_____Date: _____

WILLIAMSON CHIROPRACTIC SERVICES, PLLC
Consent for Chiropractic Care

Patient Name: _____ D.O.B: _____ Date: _____

By reading below, I have been made aware:

1. The process of delivering a "Chiropractic Adjustment" (manipulation) may be performed manually by hand, with a table mechanism, or with a hand-held instrument to vertebra(e) of the spine and/or associated structures often resulting in an audible pop or click sound;
2. That on occasion, some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling and even more rare, separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment;
3. That the chiropractor has made no guarantee of a positive outcome from treatment.

Additionally:

1. I have been afforded ample opportunity for questions and answers.

THEREFORE, BY SIGNING BELOW:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or the staff under the direction and supervision of the office chiropractor involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direct supervision of the office chiropractor involved in my case.

I understand the risks and benefits associated with chiropractic care and am willing to accept care on this basis.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian:_____Date: _____