Williams Family Chiropractic Clinic

Tell us About You

First: _____ M: _____ Last: _____ Nickname: _____

Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female SS#: _____ - _____ - _____

Current Address: _____ City: _____ State: _____ Zip: _____

Primary Telephone: _____H/W/C Alternate telephone: _____ H/W/C

Email: _____ Who may we thank for referring you? _____

Marital Status: ☐ Single ☐ Divorced ☐ Widow ☐ Married to: _____

# of Children: ____ Ages of Children: _____ Emergency Contact: _____

Phone: _____ Emergency Contact is your: ☐ Spouse/partner ☐ Parent ☐ Other: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Self ☐ Retired

Occupation: _____ Employer: _____

Student: ☐ No ☐ Full-time ☐ Part-time School name: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race (Please circle one) American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Decline to Answer

Ethnicity (Please circle one) Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Tell Us Why You're Here

What is your primary reason for your visit? _____

Is this due to a: ☐ Auto Accident ☐ Worker's Compensation Accident ☐ Personal Injury Case ☐ Health Assessment ☐ Other: _____

When did your pain/symptoms begin? (include date if possible): _____

The severity of your complaint is: ☐ Mild ☐ Mild-Moderate ☐ Moderate ☐ Moderate-Severe ☐ Severe

On a scale of 0-10, how would you rate your pain/symptoms today? (Please circle a number or range below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst Possible

The overall frequency is: ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

If your symptoms change, when are they worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ N/A

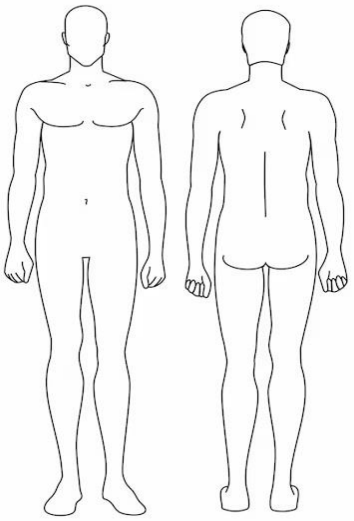
Are your symptoms/pain getting: ☐ Better ☐ Worse ☐ Staying the same

Have you had any recent treatment for this condition? ☐ No ☐ Yes (If Yes, please list dates and doctors):

_____

Have you had the same or similar problems in the past? ☐ No ☐ Yes - when: _____

Use the following key to mark your complaints on the diagram on the right:



Pain = P Numbness = N

Soreness = O Stiffness = X

Weakness = W Swelling = S

Burning = B Tingling = T

If your complaints include pain, how would you describe it?

(Please check all the apply) ☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing ☐ Other: _____

Since your symptoms began, have you noticed any changes in: ☐ Bowel ☐ Bladder ☐ Sexual ☐ N/A

Do your work activities aggravate your present complaints? ☐ Yes ☐ No ☐ N/A

How often does your job require lifting? ☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Other job requirements (please check all that apply): ☐ Bending ☐ Carrying ☐ Stooping ☐ Twisting ☐ Turning ☐ Walking ☐ Other: _____

What is your primary position at work? ☐ Seated ☐ Standing ☐ Driving ☐ Other: _____

Sickness, Injury and Accident History

* Include DATES, DESCRIPTIONS and specify (R) ight side, (L) eft side or (B) ilaterally as applicable

Accidents (include automobile, work-related, personal injury, slip & fall, or any serious injury):

_____

_____

Prior illnesses (other than colds and flu): _____

_____

Surgeries and Hospitalizations : _____

_____

Your Activities of Daily Living

Please indicate which activities of daily living are compromised by your current state of health:

☐ Walking	☐ Playing an instrument	☐ Swimming	☐ Vacuuming	☐ Running
☐ Sitting	☐ Using telephone	☐ Ironing	☐ Bending	☐ Raking
☐ Washing dishes	☐ Carrying objects	☐ Sports	☐ Climbing stairs	☐ Chewing
☐ Kneeling	☐ Getting in/out of care	☐ Shaving	☐ Driving a car	☐ Gardening
☐ Sleeping	☐ Lying in bed	☐ Riding a car	☐ Reading	☐ Standing
☐ Other travel	☐ Cooking	☐ Exercising	☐ Writing	☐ _____
☐ Standing	☐ Sewing or crafts	☐ Making bed	☐ Brushing Teeth	☐ _____
☐ Lifting children	☐ Sitting in recliner	☐ Doing laundry	☐ Combing hair	☐ _____
☐ Using Computer	☐ Caring for pets	☐ In/Out of bed	☐ Shoveling snow	☐ None

Tell Us About Your Family Health History

Relative	Illness (if no family illness, check here: ☐)	Age	Cause of Death
Mother	_____	_____	_____
Father	_____	_____	_____
Sister 1	_____	_____	_____
Sister 2	_____	_____	_____
Brother 1	_____	_____	_____
Brother 2	_____	_____	_____

Your Lifestyle & Social History

Using a scale from 0 to 10, where 0 equals “awful” and 10 = “amazing”, how would you rate your overall health? (Please circle): 0 1 2 3 4 5 6 7 8 9 10

On a scale of 0 to 10, how would you rate an average day of stress in your life? (Please circle)

No Stress = 0 1 2 3 4 5 6 7 8 9 10 = Very Stressful

Do you feel that your problems are from or are made worse by (Please check all that apply):

☐ Physical stress ☐ Chemical stress ☐ Emotional stress

Where in your body do you feel you hold or carry your stress? _____

How many hours do you sleep each night? _____ Is it easy to fall/stay asleep? (Please circle) Y or N

What habits do you feel you need to release in order to get better? _____

On a scale of 0 to 10, how would you rate your commitment level to get better? (Please circle)

Not committed = 0 1 2 3 4 5 6 7 8 9 10 = Very committed

Do you exercise? ☐ No ☐ Yes- How often? _____

How many caffeinated drinks do you consume: _____ per day

How many alcoholic drinks do you consume: _____ per week

Smoking Status: (Please circle one): Never Smoked / Occasional Smoker / Former Smoker / Daily Smoker (# packs per day _____)

Have you ever been to a doctor of chiropractic before? ☐ No ☐ Yes - How long ago? _____

Name of prior D.C. _____ City/State: _____

Do you see a medical doctor or osteopath? ☐ No ☐ Yes- Date of last visit: _____

Name of MD/DO: _____ City/State: _____

Women only: To your knowledge are you pregnant? ☐ No ☐ Yes- Due Date? _____

Are you currently taking any medications (Please also include any regularly used over the counter medications.

Do you have any medication allergies?

Medicine Name	Reaction	Onset Date	Additional Comments

For Office Use Only

Height: _____ Weight: _____ Blood Pressure: _____/_____ (R / L)

Please mark whether you NOW have or have had IN THE PAST any of the following conditions:

NOW	PAST		NOW	PAST		NOW	PAST	
☐	☐	Allergies	☐	☐	Difficulty Swallowing	☐	☐	Prostate Trouble
☐	☐	Hay Fever	☐	☐	Sinus Trouble	☐	☐	Erectile Issues
☐	☐	Fatigue	☐	☐	Wheezing	☐	☐	Fertility Problems
☐	☐	Jaw Pain/TMJ	☐	☐	Chronic Cough	☐	☐	Excessive Thirst
☐	☐	Skin Problems	☐	☐	Chest Pain/Pressure	☐	☐	Anxiety/Nervous
☐	☐	Loss of Balance	☐	☐	Heart Trouble	☐	☐	Mood Swings
☐	☐	Dizziness	☐	☐	High Blood Pressure	☐	☐	Mental/Emotional
☐	☐	Vertigo	☐	☐	Low Blood Pressure	☐	☐	Depression
☐	☐	Asthma	☐	☐	Night Sweats	☐	☐	Weakness
☐	☐	Fainting	☐	☐	Cold Hands/Feet	☐	☐	Arthritis
☐	☐	Headaches	☐	☐	Abdominal Pain	☐	☐	Bone Fracture
☐	☐	Seizures	☐	☐	Heartburn/Indigestion	☐	☐	Dislocated Joints
☐	☐	Memory Loss	☐	☐	Excess Gas	☐	☐	Autoimmune
☐	☐	Vision Trouble	☐	☐	Constipation	☐	☐	Cancer
☐	☐	Hearing Trouble	☐	☐	Diarrhea	☐	☐	Rheumatic Fever
☐	☐	Ear Infections	☐	☐	Nausea/Vomiting	☐	☐	Multiple Sclerosis
☐	☐	Ringing in Ears	☐	☐	Bedwetting	☐	☐	Fibromyalgia
☐	☐	Loss of Smell	☐	☐	Urinary pain/Frequency	☐	☐	Tuberculosis
☐	☐	Loss of Taste	☐	☐	Blood in Urine/Stool	☐	☐	Other: _____
☐	☐	Diabetes	☐	☐	Menstrual problems	☐	☐	Other: _____
☐	☐	Sleeping Problems	☐	☐	Shortness of Breath	☐	☐	Thyroid Trouble

Communication is Key to a Positive Relationship

Is there anything else that you would like us to know? ☐ No ☐ Yes – _____

I do hereby acknowledge that to the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be detrimental to my health. It is my responsibility to inform Williams Family Chiropractic Clinic of any changes in my health status.

Name of Patient: X_____ Date: X _____

Personal Representative: X_____ Relationship to patient: _____

Signature: X_____ Witness: _____

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Zac Williams and/or other licensed doctors of chiropractic who now or in the future work at Williams Family Chiropractic Clinic. I understand that I will have an opportunity to discuss with Dr. Zac Williams and/or other doctors employed at Williams Family Chiropractic Clinic the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed, as in the practice of medicine, that in the practice of chiropractic, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains or strains. I do not expect Dr Williams to be able to anticipate all risks and complications, and I wish to rely upon Dr. Zac Williams and other chiropractors employed by Williams Family Chiropractic Clinic to exercise judgement during the course of the procedures which Dr. Williams and/or other chiropractors employed at this clinic who oversee and provide care to me feel at the time, based upon the facts known to them at the time, is in my best interest. I have read, or have read to me, the above content. I have had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: X_____ Date: X _____

Patient Printed Name: X_____ Witness: _____

(For parents or legal guardians only) Consent to care for a minor: I hereby authorize Williams Family Chiropractic Clinic to care as deemed necessary to:

Printed name of minor patient: X_____ Date: X _____

Printed parent or legal guardian name: X_____ Signature: X_____

AUTHORIZATION, ASSIGNMENT, ACKNOWLEDGEMENT AND UNDERSTANDING

Past Due Accounts: Accounts not paid within 120 days will be automatically sent to a collection agency.

Medicare Assignment: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in a place of the original and request payment of medical insurance benefits, whether to myself or to the party who accepts assignments below.

X-Rays: It is understood and agreed that the amount paid to the doctor for his x-rays is for the examination and reading of the x-ray only. Since Williams Family Chiropractic Clinic is legally responsible for the x-rays, they will remain property of the office. The x-rays may be viewed in the office at Williams Family Chiropractic Clinic free of charge in accordance with the office HIPAA procedures. In addition, I understand that I can request a copy of my x-rays and that copy fees will apply and will be due at the time the request is submitted. I understand that my request for x-ray copies will need to be submitted to Williams Family Chiropractic Clinic in writing in accordance with the office HIPAA procedures and that they have up to 30 days to respond to this request.

Safety Notice: I understand that chiropractic adjusting tables and office equipment is not intended to be played with or around by children. I agree to supervise my children while I am at Williams Family Chiropractic Clinic to prevent any injury from touching adjusting table mechanics or any other office equipment. I understand that Williams Family Chiropractic nor their employees or owners may be held responsible for any injuries that result from lack of supervision of my children.

Obligations as to Services: hereby acknowledge that I am receiving (or about to receive) health care services at Williams Family Chiropractic Clinic, and that I have been advised that Williams Family Chiropractic Clinic is willing to wait for payment for these services so long as there continues to be a likelihood that payment that will be made either by my insurance company and/or out of the settlement of my liability case. I understand and agree that, in the event that:

A. It is determined that there is no insurance company obligation to pay for Williams Family Chiropractic Clinic's services;
B. The insurance company for the undersigned refuses to acknowledge an assignment to Williams Family Chiropractic Clinic or to take other actions for the protection of the interest of Williams Family Chiropractic Clinic;
C. My attorney fails and/or refuses to agree to protect the interest of Williams Family Chiropractic Clinic as determined in its sole discretion; or
D. If I fail to retain an attorney, then payment of services at Williams Family Chiropractic Clinic will be made on a current basis and my bill paid in full within thirty (30) days from my last treatment.

I hereby authorize the doctor(s) to treat any condition they may deem appropriate through the use of, but not limited to, spinal adjustments, x-ray diagnostics and physical therapy modalities. I, the client, also agree to be responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, or for any medical diagnoses.

By my signature below, I make the foregoing authorizations, assignments and agreements.

Patient Signature: X_____ Date: X _____

Patient Printed Name: X_____ Witness: _____

APPOINTMENT POLICY

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels are best for you. In order to receive optimum results, it is very important that you follow the care plan that the doctor recommends for you. The frequency of your treatment schedule and your commitment level of following doctor's recommendations is of paramount importance to your results. If for any reason you are unable to keep an appointment, please call Williams Family Chiropractic Clinic immediately to reschedule your appointment. In order to receive the results, you are expecting, it is recommended that missed appointments be made up as soon as possible. If obstacles arise that will prevent you from keeping your appointments according to your care plan, then please call us immediately, so that we can help work out a solution for you. If you are late for an appointment, our staff will try reaching out to you approximately 15 minutes after our scheduled time. We will call you at the phone numbers that you provided on your intake forms, and if there is no answer, a message will be left on your voicemail. If life circumstances require you to end care at our office, please notify our office immediately, so that we can make note in your file. Proper health care is a two-way street, meaning that both the doctor and the patient have various responsibilities, to uphold if you are to receive maximum benefits and attain optimal improvements. Natural healing requires joint cooperation! I have read the Appointment policy.

Patient Signature: X_____ Date: X _____

Patient Printed Name: X_____ Witness: _____

Williams Family Chiropractic Clinic

6910 N Main St., Ste. #5 Granger, IN 46530

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Williams Family Chiropractic Clinic's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____

(Print) **Date**

Signature of Personal Representative: _____

Relationship to Patient: _____ **Driver's License Number:** _____ **State**____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

OFFICE USE ONLY

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Attempt 1 Date _____ Staff_____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Attempt 2 Date _____ Staff _____

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgement.
- ❑ Other (Specify:)_____

Williams Family Chiropractic Clinic

6910 N Main St., Ste. #5 Granger, IN 46530

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. We have **permission** to **(please check all that apply)**:

- ❑ Leave messages on home phone or with household members about appointments, and test results.
- ❑ Leave messages on work phone about appointments, and test results.
- ❑ Leave messages on cell phone about appointments, and test results.
- ❑ Email appointment reminders
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____/____/____

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative.

I hereby authorize the practice to disclose my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

I understand that I may revoke this authorization to disclose information at any time by notifying the practice in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by the clinic until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

_____ _____

Signature of Personal Representative **Date**

Relationship to Patient: _____ **Driver's License Number:** _____ **State**____

Williams Family Chiropractic Clinic

Zac Williams, D.C.

CONSENT FOR AUTHORIZATION TO PERFORM AND RELEASE X-RAYS

Patient Consent

I authorize Zac Williams, D.C. to perform diagnostic x-rays on myself and if necessary send to Radiologist for a full radiological report.

Patient Name_____

Signature_____ Date_____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant and the Doctor has my permission to perform x-rays.

Signature_____ Date_____

If Patient is a Minor

I am the parent or legal representative of _____. I authorize the performance of diagnostic x-rays of this minor.

Signature_____ Date_____