Wilson Family Chiropractic
Patient History Form

(Please Print)

Date ___________

Name ____ Home Phone ________________
Is the problem related to: auto __ work __ home __ leisure __ sports __ fall __ other __ unsure __

Date of Accident/Symptoms started __________
What is your major complaint? ____
Other complaints ____
How long have you had this condition? ______________
Have you h ad this condition in the past? ____________
Pains are: Sharp __ Dull __ Constant __ Comes and Goes __
What activities aggravate your condition/pain? ___________________________
What activities lessen your condition/pain? ______________________________
Is the condition worse during certain times of the day? ________
Does this condition interfere with work? __ Sleep __ Routine __Other __
Is the condition getting progressively worse? _____________________________
Other Doctors you have seen for this condition ____________________________
Any home remedies? ____
List ALL past accidents/injuries and dates _________________________________
____
List ALL past surgeries and year ____
____
List any SERIOUS illnesses present/past ___________________________________
List ALL medications taken in the past 6 months ____________________________
____
List any herbs, vitamins, or home remedies you are taking ___________________
____
Do you smoke? ____________ Use alcohol? ____________ Use aspirin? ____________
Any similar family history? ____
WOMEN ONLY: Are you pregnant or a possibility? __________________________
At work are you seated ___ standing ___ desk ___ counter ___bench work ___
Work strain is light ___ moderate ___ heavy ___ strenuous ___
Do you exercise? _________ What type? _________

C= Current Condition P= Past Condition *Next to each Condition it applies*

___ Allergy	___ Painful Tail Bone	___ Weight Loss
___ Dizziness	___ Swollen Joints	___ High Blood Pressure
___ Fainting	___ Neck Pain/Stiffness	___ Chest Pains
___ Fatigue	___ Digestive Disorders	___ Sinus Problems
___ Headache	___ Constipation	___ Coughing
___ Loss of Sleep	___ Fever	___ Urinary Problems
___ Nervousness	___ Asthma	___ Menstrual Problems
___ Depression	___ Earache	___ Cancer
___ Numbness in: __ shoulder/arm/elbows/hands __ hips/legs/knees/feet	___ Diabetes	___ Stroke

I understand and agree that health insurance is an arrangement between myself and my insurance company. I understand that this office will prepare necessary reports to assist me in collection from my carrier. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for any balance that the insurance does not cover.

Signature ______________________________ Date ______________________
(Guardian if Applicable)

Minor Patients (Parents must check)

___Permit doctor to examine only ______________

__ Permit doctor to examine and treat without parent present ______________

__ Permit doctor to examine and treat with parent present ______________

Signature of File

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

______________________ ______________________

Patient Signature Date

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

____

Patient Signature