Dr. Don Williams, D.C. - Vibrant Living Center

Patient Personal History

Date: _____ Email: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Birth Date: _____ Age: _____ Sex: M F

Business/Employer: _____ Type of Work: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated # of Children: _____

Name of Emergency Contact: _____ Phone #: _____

Referred to this office by: _____

Current Health Condition

Purpose of this appointment: _____

_____

Other doctors seen for this condition? _____

When did this condition begin? _____ If disabled from work, please give date: _____

Drugs you take now: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine ☐ Insulin

☐ Other _____

Past Health History

Please check or describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Broken Bones

Other: _____

Major Accidents or Falls: _____

Hospitalization (Other than above): _____

Previous Chiropractic Care – Doctor's Name and Approximate Date of Last Visit: _____

Have you been treated for any health condition in the last year? ☐ Yes ☐ No If Yes, please explain:

_____

_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Clicking Jaw
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL CODE

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heart Beat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

FEMALES ONLY:

When was your last period? _____

Are you pregnant? ☐Yes ☐No ☐Maybe

For Doctor Use Only:

Diagnosis:

Patient Accepted ☐ Yes ☐ No

Dr. Don Williams, D.C. - Vibrant Living Center

Statement of Intent

Our primary goal for your care is to help you achieve vibrant health by addressing the cause of your condition. Our evaluation will determine how your body is functioning. Through gentle hands-on care and education, interference is removed and balance is restored. As you become more aware of your Self and body, your perception of the powerful Innate Intelligence within you will strengthen, supporting you to make positive changes in your life. This Intelligence is what guides our bodies through its daily actions, including the healing process. We share our goal so you may understand it and the means by which it is attained. We are excited to share in your healing journey.

Please realize that we do not diagnose any ailment or diseases. We encourage any individual having concerns about symptoms or disease to consult his or her medical doctor at any time during chiropractic care.

Consent to Care

I, _____, have read the above, understand if fully and choose to receive chiropractic care.

Signature: _____ Date: _____

Signature of parent or guardian if a minor: _____

Payment Agreement

I understand that a fee for services rendered at The Vibrant Living Center will be charged and I am responsible for this fee. If I choose to suspend or terminate care, I understand that all fees for services rendered at The Vibrant Living Center are due and payable at that time.

Signature: _____ Date: _____

Signature of parent or guardian if a minor: _____

Cancellation Policy

If you are unable to make your appointment, we ask that you give 24 hours notice. This advanced notice is greatly appreciated. Cancellations less than 24 hours or no shows will be charged the full appointment fee, unless an emergency or sudden illness occurs.

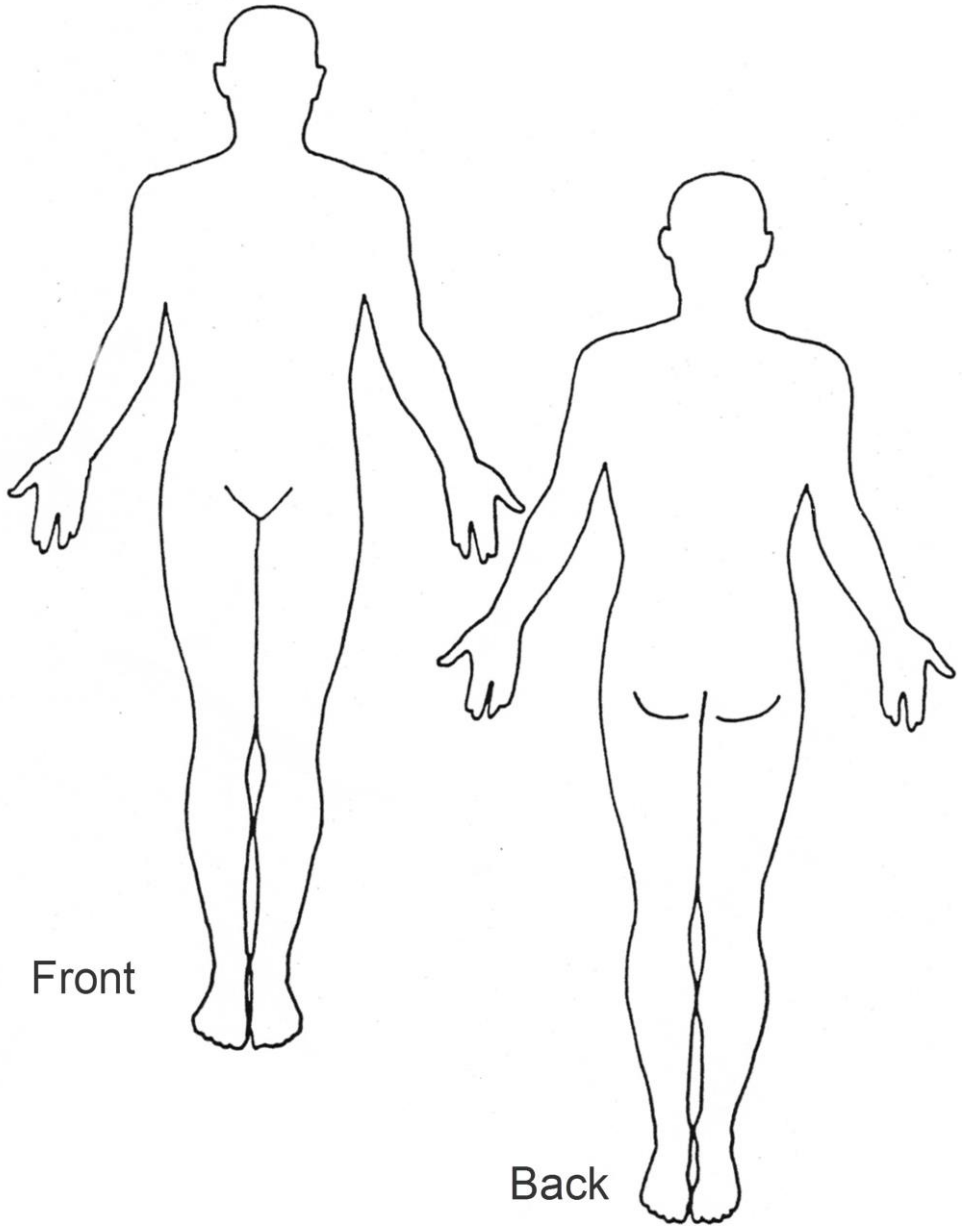
Dr. Don Williams, D.C. - Vibrant Living Center

Name _____ Date _____

PAIN DRAWING

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and stabbing = ++++	Dull and achy = VVVV
Pins and Needles = 0000	Numbness = ////



Pain Scale:

Back 0 _____ 10 Leg 0 _____ 10