WILLIAMSTON

SPORTSPINE

CHIROPRACTIC | MASSAGE | NUTRITION

Name: ______________________________ SSN: __ __ __ - __ __ - __ __ __ __ DOB: __ __ - __ __ - __ __ __ __

Sex: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Address: ____
(Street Address) (City) (Zip Code)

Phone: Home _ _ _ - _ _ _ - _ _ _ _ Work _ _ _ - _ _ _ - _ _ _ _ Cell _ _ _ - _ _ _ - _ _ _ _ Cell Carrier ______________

Email Address: ____

How would you like to receive appointment reminders? Email ☐ Text Message ☐ Both ☐

Occupation: ______________________ Employer: ______________________________

Insurance Company: ______________________ Insured Name: ______________________

Insured DOB: __ __ - __ __ - __ __ __ __ Insurance ID: ______________________________

Family Physician: ______________________________ City: ______________________

Emergency Contact: ______________________________ Phone: ______________________

How did you hear about us? Google ☐ Facebook ☐ Friend ☐ Employee ☐ Name: ______________________

Other: ____

Please circle any of the following you are experiencing or have experienced.

GENERAL
Allergies
Depression
Dizziness
Fainting
Fatigue
Headaches
Loss of sleep
Mental Illness
Nervousness
Tremors
Weight loss/gain

MUSCLE/JOINT
Arthritis
Rheumatism
Bursitis
Muscle Weakness
Low back pain
Neck Pain
Mid back pain
Joint Pain

SKIN
Boils
Bruise Easily
Dryness
Hives or Allergies
Rash
Varicose Veins

EYE, EAR, NOSE & THROAT
Colds
Deafness
Ear ache
Eye pain
Hoarseness
Nose bleeds
Ringing of the ears
Sinus infection
Tonsillitis
Vision Problems

GASTROINTESTINAL
Abdominal Pain
Bloody or Tarry Stool
Colitis/Crohn's
Constipation
Diarrhea
Difficult Digestion
Bloated Abdomen
Excessive Hunger
Gallbladder trouble
Hernia
Hemorrhoids
Intestinal Worms
Jaundice
Liver trouble
Nausea
Painful defecation
Pain over stomach
Poor appetite
Vomiting
Vomiting of blood

GENITOURINARY
Bed-wetting
Bladder infection
Blood in urine
Kidney infection
Kidney stones
Prostate trouble
Stress incontinence

URINATION
Decreased flow/force
Painful urination
Urgency to urinate
More than 8x in 24 hrs.

CARDIOVASCULAR
High blood pressure
Low blood pressure
Irregular pulse
Pain over heart
Palpitation
Poor circulation
Rapid heart beat
Slow heart beat
Swelling of ankles

RESPIRATORY
Chest pain
Chronic cough
Difficulty breathing
Hay fever
Shortness of breath
Wheezing

WOMEN ONLY
Congested breasts
Miscarriage
Hot flashes
Fibroids
Menopause
Menstrual Flow:
Reg. ☐ Irreg. ☐ Pain ☐
Days of flow: _____
Are you pregnant?
Yes ☐ No ☐
If yes, How many months? _________
How many children do you have?
____

MISCELLANEOUS:
Alcoholism
Anemia
Appendicitis
Arteriosclerosis
Asthma
Bronchitis
Cancer
Chicken Pox
Cold sores
Diabetes
Eczema
Emphysema
Epilepsy
Goiter
Gout
Heart burn
Heart disease
Hepatitis
Herpes
High Cholesterol
HIV/AIDS
Influenza
Malaria
Multiple sclerosis
Numbness/Tingling
Pace maker
Osteoporosis
Pneumonia
Polio
Rheumatic fever
Stroke
Thyroid disease
Tuberculosis
Ulcer

Give a brief detailed description of the problem you are currently experiencing:

____

____

____

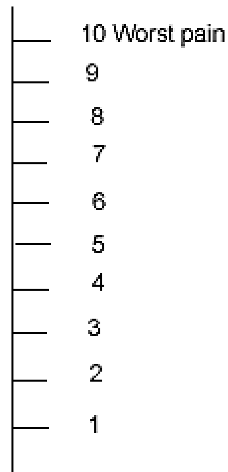
How long have you had this condition? ____________________________ Is it getting worse? Yes ☐ No ☐

Does your pain bother you during any of the following (check appropriate box)? Work ☐ Sleep ☐ Other ☐

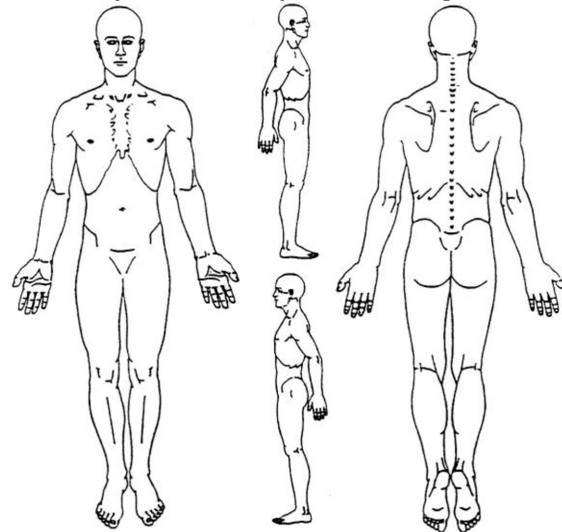
Please explain: ____

What was the initial cause? ____

Please mark at the level of your pain on the scale below.



Please mark your areas of pain on the figure below.



Past Health History

Have you…	Yes	No	If yes, explain briefly
…been hospitalized in the last 5 years?	☐	☐	____________________
…had any mental disorders?	☐	☐	____________________
…had any broken bones?	☐	☐	____________________
…had any strains or sprains?	☐	☐	____________________
…ever used orthotics?	☐	☐	____________________
Do you take minerals, herbs or vitamins?	☐	☐	____________________

How is most of your day spent? Standing ☐ Sitting ☐ Other ☐ ________________________________

How old is your mattress? ____________________________________

When was your last physical exam? ____

Family History

If any blood relative had had any of the following conditions, please circle and indicate which relative.

Alcoholism	Cancer	High Blood Pressure
Anemia	Diabetes	High Cholesterol
Arteriosclerosis	Emphysema	Multiple Sclerosis
Arthritis	Epilepsy	Osteoporosis
Asthma	Glaucoma	Stroke
Bleeding easily	Heart Disease	Thyroid Disease

How many cups of coffee do you drink a day? ______

If you smoke, how many packs a day? ______

How many sodas do you drink a day? ____________

Please list all medications. ____________________________________

____

____

How much water do you drink a day? ____________

How often do you exercise? ____________________

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CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment.
b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.
c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spinal manipulation is extremely rare.

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. The Journal of the American Medical Association recommends using non-invasive treatments for acute low back pain first, including chiropractic care. Musculoskeletal care contributes to your overall well-being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I understand the following:

a. The condition that the treatment is to address;
b. The nature of the treatment;
c. The risks and benefits of that treatment; and
d. Any alternatives to that treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intent this consent to apply to all my present and future care with Williamston Sport and Spine.

Date: __ __ - __ __ - __ __ __ __

____
Patient signature (or Legal Guardian)

____
Print Name

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FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST CARE POSSIBLE. IN ORDER TO ACHIEVE THESE GOALS, **WE NEED YOUR UNDERSTANDING OF OUR PAYMENT POLICY.**

- **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**, UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF. WE ACCEPT CASH, CHECKS OR CREDIT CARD**.**
- IF YOU HAVE MEDICAL INSURANCE THAT COVERS CHIROPRACTIC SERVICES, WE ARE PREPARED TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. **INSURANCE CO-PAYMENTS ARE DUE AT EACH OFFICE VISIT**

IF YOU HAVE ANY QUESTIONS ABOUT THE ABOVE INFORMATION, OR ANY UNCERTAINTY REGARDING INSURANCE COVERAGE, PLEASE DON'T HESITATE TO ASK. WE ARE HERE TO HELP IN ANY WAY POSSIBLE.

*I UNDERSTAND THAT, REGARDLESS OF MY INSURANCE STATUS**, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.***

____ ____________________________

PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE DATE

____ ____________________________

PARENT (if minor) DATE

ASSIGNMENT

I HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO WILLIAMSTON SPORT AND SPINE*, THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED BY THIS CLINIC. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.*

____ _________________________

PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE DATE

RELEASE OF INFORMATION

***I AUTHORIZE WILLIAMSTON SPORT AND SPINE TO RELEASE ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY,** ADJUSTOR AND ATTORNEY IINVOLVED IN THIS CASE; AND HEREBY RELEASE WILLIAMSTON SPORT AND SPINE OF ANY CONSEQUENCE THEREOF.*

____ ____________________________

PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE DATE

FINANCIAL RESPONSIBILITY

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AT WILLIAMSTON SPORT AND SPINE INCLUDING MY INSURANCE DEDUCTIBLE, COPAYMENT AND ANY SERVICES REJECTED BY MY INSURANCE COMPANY.

____ _________________________

PATIENT SIGNATURE OR PERSONAL REPRESENTATIVE DATE