



**WILLIAMS INTEGRACARE  
CLINIC**

one body. one solution. one place

**Patient Information**

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Major Complaint Information**

What is your major complaint(s)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When did this symptom(s) begin?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please shade in the area where you are experiencing pain.

If this is an injury, describe what happened.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you experienced these symptoms before?  Yes  No

When? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What aggravates this condition? \_\_\_\_\_

What decreases the symptoms / pain? \_\_\_\_\_

Have you seen another doctor for this condition?  Yes  No Doctor's Name: \_\_\_\_\_

Date consulted: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

If female, are you pregnant?  Yes  No  Not Sure If no or not sure, date of your last menstrual period: \_\_\_\_\_

List all medications you are taking now, including over the counter medication. \_\_\_\_\_

Are you allergic to any medications?  Yes  No  Not Sure Please list: \_\_\_\_\_

Have you ever had any surgeries or hospitalizations?  Yes  No Please list:

Type of Hospitalization/Surgery: \_\_\_\_\_ Date \_\_\_\_\_

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Medical Problems: \_\_\_\_\_

Who Referred You to Williams Integracare Clinic? \_\_\_\_\_

*IF YOURS IS AN AUTO OR WORK ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS*

**Personal Injury**

Date of Accident: \_\_\_\_\_ Hour \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ Location: \_\_\_\_\_

How did accident occur? \_\_\_\_\_ Auto Collision \_\_\_\_\_ On-the-job injury \_\_\_\_\_ Other: \_\_\_\_\_

Please describe the accident or injury \_\_\_\_\_

If work related, did you report the injury to your foreman or employer?  Yes  No

If work related, name and phone number of foreman or authorized person \_\_\_\_\_

If auto accident were you  Driver  Passenger  Pedestrian

**Family History**

	Self Age ( )	Father Age ( )	Mother Age ( )	Spouse Age ( )	Brother(s) Age ( )	Sister(s) Age ( )	Children Age ( )
Arthritis							
Asthma							
Back Pain							
Bursitis							
Cancer							
Diabetes							
Disc Problems							
Emphysema							
Epilepsy							
Headaches							
Heart Trouble							
High Blood Pressure							
Insomnia							
Kidney Trouble							
Migraines							
Nervousness							
Scoliosis							
Sinus Trouble							
Stomach Trouble							
Other							