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?

____

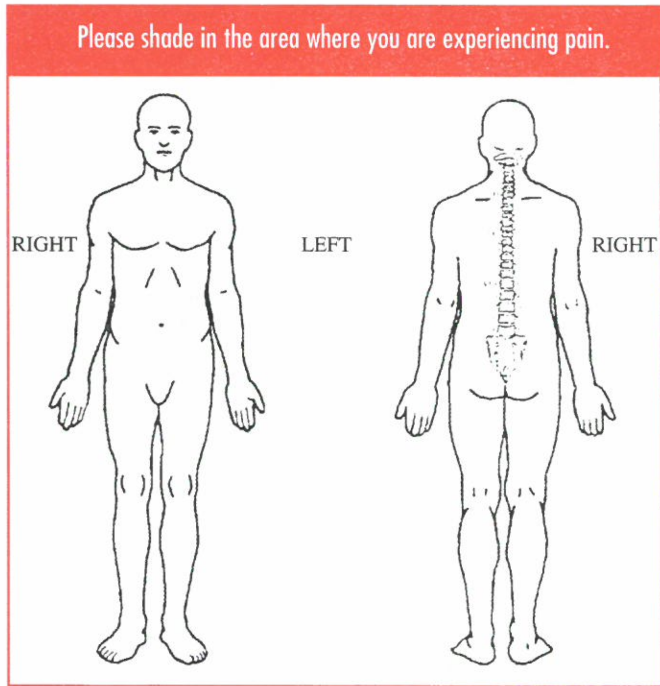
____

____

____

____

Please shade in the area where you are experiencing pain.



If this is an injury, describe what happened.

____

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____

____

____

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 Refered 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							