WILLIAMS INTEGRACARE CLINIC

one body. one solution. one place

Patient Information

Date: _____

Date of Birth: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Email: _____ Cell Phone: _____

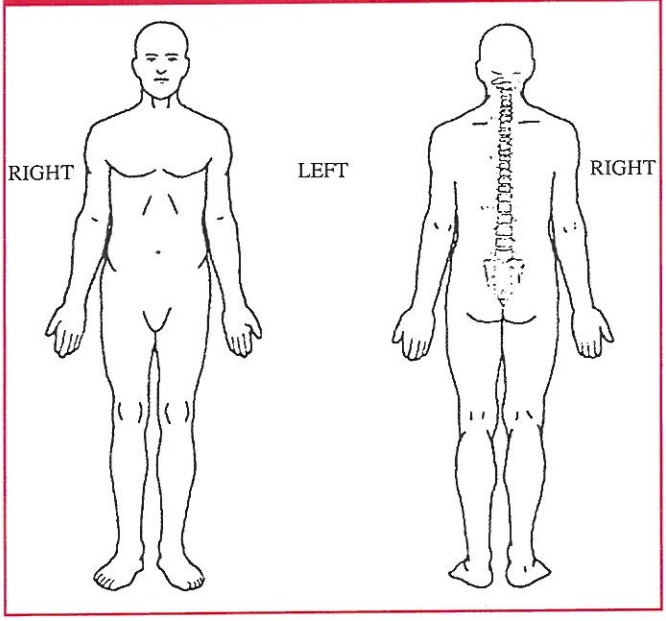
Major Complaint Information

What is your major complaint(s)? _____

_____

_____

Please shade in the area where you are experiencing pain.



When did this symptom(s) begin?

_____

_____

_____

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 _____

Type of Hospitalization/Surgery: _____ Date _____

Type of Hospitalization/Surgery: _____ Date _____

Medical Problems: _____

_____

Who Refered You to Williams Integracare Clinic? _____

Check those activities below during which you experience difficulty or pain:

○Lying on back	○Getting in/out of car	○Pulling	○Sitting	○Standing for long periods
○Lying on side	○Dressing Self	○Reaching	○Bending forward	○Sneezing
○Turning over in bed	○Sexual Activity	○Kneeling	○Bending backward	○Coughing
○Lying flat on stomach	○Pushing	○Stooping	○Walking	○Other:_____

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

If auto collision, were you struck from ○Behind ○Right Side ○Left Side ○Front ○Auto was parked

If auto accident, did your car strike the other(s) involved? ○Yes ○No

Or did the other car strike yours? ○Yes ○No ○Undetermined Did your vehicle's airbag deploy? ○Yes ○No

Were you wearing a seat belt? ○Yes ○No Did your body strike any objects in the car? ○Yes ○No

List Object(s) struck:_____ Lost work time ○Yes ○No If yes, date you returned to work _____

Do you have an attorney who has advised you in this case? ○Yes ○No Attorney Name: _____

Attorney's Address: _____ Phone #: ( ) _____

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							