Dr. Thomas Williams
4384 Clearwater Way, Suite 160
Lexington, KY 40515
859.523.1915 · www.welladjustedcenter.com
"Life is better when you're WELLadjusted"

We are happy you have chosen us for your Chiropractic Wellness Care.
Please fill out these forms so Dr. Williams can establish a complete record of your personal health needs.

PLEASE PRINT

First Name:________________________________ M.I._______ Last Name:_______________________________

Home Address: ____City________________Zip____________

Home Phone: _(___)________________ Cell: _(__ _)________________ Email: ___________________________

Birth date:______/_______/_______ Sex: □ Female □ Male

Marital Status: □ Single □ Married □ Widow □ Divorced □ Partner How many children? _____________

Employed: □Full-time □Part-time Student: □Full-time □Part-Time □Self-Employed □Unemployed □ Retired

Occupation:__________________________ Employer:_________________________ Work #:(_ __)____________

Employer address: ____

Name of Partner/Spouse: ____Partner/Spouse Birthdate: _________

Partner/Spouse's Employer:____ Work #: (___)___________

Referred by: ____

Person to contact in an emergency? ______________________________________ Phone: (_____) _______________

Family Physician ____

STANDARD AUTHORIZATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby voluntarily authorize, WELLadjusted: a chiropractic wellness center, to release any and all medical information, until this authorization is further revoked, to:

____Relationship:__________________
____Relationship:__________________
____Medical Doctor

I understand that if the person or organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Signature of Patient: ____ Date: __________________

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

Please mark the following conditions if they pertain to you.
Mark an "O" if it is a Past Condition or an "X" for a Present Condition.

______ Auto Accidents
______ (a) 0-1 years ago
______ (b) 1-5 years ago
______ (c) More than 5 yrs ago
______ Other Accidents/ Falls
______ Fractured Bones
______ Knocked Unconscious
______ Convulsions/ Epilepsy
______ Diabetes
______ Cancer
______ Stroke
______ High/low blood pressure
______ Chest Pain
______ Lung Problems
______ Sinus Problems
______ Difficult breathing
______ Asthma
______ Allergy
______ Arthritis
______ Gall Bladder trouble
______ Kidney trouble
______ Liver Trouble
______ Ulcers
______ Hemorrhoids
______ Frequent urination
______ Hearing Loss R / L
______ Blurred /Double Vision R / L

______ Headache
______ Jaw Pain/ click (TMJ)
______ Shoulder Pain R / L
______ Neck pain/ stiffness
______ Mid -Low back pain
______ Hip Pain R / L
______ Foot trouble R / L
______ Impotence
______ Prostate Problems
______ Menopausal problems
______ Menstrual problems / PMS
______ Breast Lumps,soreness,discharge
______ Venereal Disease
______ Heartburn
______ Belching/ Bloating
______ Excessive Gas
______ Diarrhea / Constipation
______ Colon Trouble
______ Digestive problems
______ Skin Problems
______ Itching
______ Excessive Sweating
______ Varicose Veins
______ Loss of Balance
______ Ear infections
______ Ringing in ears R / L
______ Mental/Emotion disorders

______ Trouble sleeping
______ Bedwetting
______ Frequent colds/ Flu
______ Back Curvature
______ Head seems too heavy
______ Anemia
______ Bruise Easily
______ Tremors
______ Light headed upon rising
______ Light bothers eyes
______ Heart Problems
______ Restless Leg Syndrome
______ Fainting
______ AIDS / HIV
______ Dyslexia
______ Learning Disability
______ Stutter
______ Loss of Memory
______ Depressed
______ Nervous
______ Trouble concentrating
______ Irritable
______ Eating disorder
______ Under Stress
______ Mood changes
______ Crave sweets/salt

Female Patients: Is there a chance you may be pregnant: □Yes □No □Unsure

FAMILY HEALTH HISTORY
Please check all that apply.

Mother:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health If deceased—Age at death: ___________

Father:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health If deceased—Age at death: ___________

Siblings:
□ Cancer □ Diabetes □ Heart □ High Blood Pressure □ Respiratory problems
□ Kidney □ Stroke □ In good health If deceased—Age at death: ___________

SOCIAL HISTORY. *Do you*:

Exercise regularly □ Yes □ No
Eat a balanced diet □ Yes □ No
Obtain sufficient rest □ Yes □ No
What is your typical breakfast? ____
What is your typical lunch? ____
What is your typical dinner? ____
What do you typically have for snacks? ____
Do you smoke? (packs/day): □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink coffee/tea? (cups/day): □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink alcohol? (drinks/day) : □ No □ Less than 1 □1-2 □2-3 □3-4 □More than 5
Do you drink soda? regular or diet and how much per day? ______________________________________
Do you typically find yourself feeling stressed? □Yes □No. Can you identify your stressors? □Always □Often □Rarely

MEDICAL HISTORY

Immunizations: (please circle all that apply)
1) Tetanus 2) Pertussis (whooping cough) 3) Diphtheria 4) German Measles 5) Measles 6) Mumps 7) Polio
Childhood Illnesses:
1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes 7) Cancer
List any serious childhood illnesses not recorded above:
____ Age (_____)
____ Age (_____)
____ Age (_____)
List any birth defects: ____
Hospitalizations & Surgeries: If you have ever been hospitalized, list reason, and dates:
____M/Y_____/_____
____M/Y_____/_____
____M/Y_____/_____
Adult Illnesses/ Injuries: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.
____M/Y_____/_____
____M/Y_____/_____
Do you have a pacemaker? □ Yes □ No

MEDICATIONS:

Medications: (include home remedies) List all medications that you are or have taken on a regular basis in the last 6 months.
A)____
B)____
C)____
Medications to which you are allergic:
A)____
B)____
C)____

I certify that the information on these forms is correct to the best of my knowledge. I will not hold Dr. Thomas Williams and any member of his staff responsible for any errors or omissions that I may have made in the completion of these forms.

Patient Signature: ____ Date: _______________________

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Thank you for choosing us for your Chiropractic Wellness care.
Please complete the following questionnaire to help us better serve your needs and understand your wellness goals.

First Name: ____________________________________ Last Name: _______________________________________

Why are you visiting us today? *(ie: pain, nutritional plans, physical training, etc)*_______________________________
____
____

What are your current complaints? ____
____

Is this condition due to an: □ Automobile Accident □ Work Injury □ Other accident □ Unknown cause □ Illness

Date symptoms appeared: _________ Have you had these symptoms before? □ Yes □ No If yes, when? __________

Previous Chiropractic Care? □ Yes □ No Doctor's Name: ______________________ Were X-rays taken? □ Yes □ No
Have you seen another doctor for this condition? □ Physician □ Physical Therapist □ Other □ Not applicable
Doctor's Name: _________________________ Date consulted: _______________ Were X-rays taken? □ Yes □ No

On a scale of 1 – 10, rate the importance for you to achieve the following:
1 = not important 10 = necessary

Get fit	1	2	3	4	5	6	7	8	9	10
Eat better	1	2	3	4	5	6	7	8	9	10
Reduce stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Reduce pain	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my posture	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness	1	2	3	4	5	6	7	8	9	10
Learn about wellness products that are right for me	1	2	3	4	5	6	7	8	9	10
Other ____	1	2	3	4	5	6	7	8	9	10

Which of the above would you say is the most important goal for you to achieve and why?
____
____

Have you ever attempted to accomplish this goal in the past? □ Yes □ No

If yes, what happened and what prevented you from maintaining your results?
____
____

What are your goals for your care here at our wellness center? *(please check all that apply)*

□ **Relief Care**: Symptomatic relief of pain or discomfort.
□ **Corrective Care**: Correcting and relieving the cause of the problem as well as the symptoms.
□ **Comprehensive Care**: Correcting the body's malfunctions and enhancing the body's ability to heal, function, and remain healthy.

When do you hope to have these goals met?
____

How do you see our clinic/Dr. Thomas Williams helping you meet these goals?
____
____
____

Do you have any questions or comments?
____
____
____

Do you wish to use your insurance or personal payment*? *(Please circle one: Insurance Personal Payment)*
Did you know we offer discounts for patients who opt to not use their insurance for care? Ask us for more details!

We appreciate referrals, were you referred by anyone today? □ Yes □ No
If yes, who referred you _____________________________________

I certify that the information on these forms is correct to the best of my knowledge. I will not hold Dr. Thomas Williams and any member of his staff responsible for any errors or omissions that I may have made in the completion of these forms.

Patient Signature: ____ Date: ______________________

We thank you for your time and look forward to meeting you at your initial visit.
Keep in mind that this form is only a 'snapshot' of the information we will need to collect from you.
The doctor will meet with you at your initial consultation to obtain your full medical history as well as establish and compile a complete record of your own personal needs.

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HIPAA Consent Form

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by WELLadjusted: a chiropractic wellness center, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of WELLadjusted: a chiropractic wellness center. I understand that diagnosis or treatment of me by Dr. Thomas Williams may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, WELLadjusted: a chiropractic wellness center, is not required to agree to the restrictions that I may request. However, if WELLadjusted: a chiropractic wellness center, agrees to a restriction that I request, the restriction is binding on WELLadjusted: a chiropractic wellness center.
I have the right to revoke this consent, in writing, at any time, except to the extent that WELLadjusted: a chiropractic wellness center, has taken action in reliance on this content.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and indentifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review WELLadjusted: a chiropractic wellness center Notice of Privacy Practices prior to signing this document. The Notice of Privacy has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations of WELLadjusted: a chiropractic wellness center. This Notice of Privacy Practices also describes my rights and WELLadjusted: a chiropractic wellness center's duties with respect to my protected health information.

WELLadjusted: a chiropractic wellness center, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices, and will make available to all patients any and all revised current notices.

______________________________	______________________________
Patient Name (*please print*)	Patient Signature
______________________________	______________________________
Signature of Legal Representative	Relationship (Guardian, Parent of Minor)

____

Date