



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 Referred You to Williams Integracare Clinic? _____

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

- | | | | | |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Lying on back | <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Pulling | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing for long periods |
| <input type="checkbox"/> Lying on side | <input type="checkbox"/> Dressing Self | <input type="checkbox"/> Reaching | <input type="checkbox"/> Bending forward | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Turning over in bed | <input type="checkbox"/> Sexual Activity | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Bending backward | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Lying flat on stomach | <input type="checkbox"/> Pushing | <input type="checkbox"/> Stooping | <input type="checkbox"/> Walking | <input type="checkbox"/> Other: _____ |

IF YOURS IS AN 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							