Wilson County Chiropractic
Dr. Brian J. Wiersma

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PATIENT INFORMATION

Full Name ____ Nickname _______________________________

Address ____ Birth Date_______________ Gender: M F

City___________________ St__________ Zip ___________ SS# __________-____________-____________

Cell Phone: _________________ Work Phone: _________________Home Phone: _______________________

Email address: ____ Your Occupation _______________________

Your Employer_________________________________ Employer Address______________________________

City_____________________ State________ Zip__________

Marital Status: S M W D Sep **Are You A Student**? Yes No / Full-Time Part-Time

Spouse/Parent Name __________________________Birth Date_______________ SS#___________________

Spouse/Parent Occupation_____________________ Spouse/Parent Employer___________________________

City________________ State__________ Zip_________

Referred by: ____

Please initial all office policies

- I authorize payment of medical benefits to this office. I understand this office files my insurance as a courtesy only and I will be responsible for any co-pay/deductible at time of service. If I discontinue services it is my responsibility to pay any and all co-pay/deductibles for previous services rendered. _______
- All negotiate payments on deductible and co-pays are made in accordance that the patient follows thru with the treatment. Otherwise, the patient will be billed for the full amount of deductible and/or full co-pay amounts. ____
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary. ______
- I give this office the right to use my name for any in-office publications, authorization may be denied or retracted by notifying the office manager. ____
- I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office. (Once information is disclosed, it may not be protected by law.) _______
- Unpaid Balances: "(Creditor) reserves the right to refer unpaid past due balances to third parties for collection. In the event that any past due balance is placed with a third party, I agree to pay any costs of such collection including agency fees, legal/attorney fees and court costs." ______

Patient's Signature____ Date_______________

Spouse or Guardian's Signature____ Date_______________

CASE HISTORY

Allergies: ____

Current Chief Complaint and History of Injury/Illness

Please list below where you hurt in the order of importance. Also the length of time you have had these complaint(s).
(Neck, upper back, lower back, hip, shoulder pain, etc…)

1.____ Right ____ Left ____ How long? ________________
2.____ Right ____ Left ____ How long? ________________
3.____ Right ____ Left ____ How long? ________________
4.____ Right ____ Left ____ How long? ________________

Is your condition(s) related to an accident? ☐ YES ☐ NO
Date of accident: _____________Type of Accident: ☐ Auto ☐ Work Related ☐ other _____________________

What words best describe your present condition(s)? (Ex. ache, burn) _____________________________________
Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe)
0 1 2 3 4 5 6 7 8 9 10
When is your condition most severe? ____
When is your condition least severe? ____
What makes your condition feel worse? ____
What makes your condition feel better? ____
What activities are difficult because of your condition(s)? ____
Have you seen any other health care provider for your present condition? ☐ YES ☐ NO
Who? ____
Current Medications____

Are you or could you be pregnant? ☐ YES ☐ NO

Are you experiencing or do you have any of the following?

☐ A sore that won't heal
☐ Any bleeding/discharge
☐ Bladder/bowel problems
☐ Difficulty swallowing
☐ Lump/thickening anywhere
☐ Night pain
☐ Persistent cough/hoarseness
☐ Wart/ mole changes
☐ Weight loss without trying
☐ None of the above

Review of Systems

In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

☐ Anxiety
☐ Atrophy
☐ Concussion
☐ Depression
☐ Difficulty walking
☐ Dizziness
☐ Extremity deformity
☐ Facial drooping
☐ Headache
☐ Joint deformity
☐ Joint locking
☐ Joint swelling
☐ Lack of coordination
☐ Limited range of motion
☐ Loss of balance
☐ Memory loss
☐ Mood swings
☐ Muscle weakness
☐ Numbness
☐ Popping noises
☐ Psychiatric disorders
☐ Seizures
☐ Sensory changes
☐ Speech problems
☐ Stiffness
☐ Tremors
☐ Twitches
☐ Vision trouble
☐ None of the above

Cardiovascular System

☐ Ankle swelling
☐ Blood clots
☐ Carotid blockage
☐ Changes in skin color
☐ Chest pain
☐ Dizziness
☐ Fainting
☐ Hypertension
☐ Jaw pain
☐ Known vascular disease
☐ Mitral valve prolapse
☐ Phlebitis
☐ Pacemaker
☐ Pin stroke
☐ Previous stroke
☐ Shortness of breath
☐ Varicose veins
☐ None of the above

Past History

List any surgeries you have had (including pacemaker, hysterectomy, appendix, tonsils, wisdom teeth, etc.)
1. _______________________Date___________ 3. ________________________Date_____________
2. _______________________Date___________ 4. ________________________Date_____________

Have you ever been hospitalized for anything in addition to surgeries? ☐ YES ☐ NO
If so, when and for what reason?
____
Have you ever been diagnosed as having a particular condition? (Diabetes, heart trouble, cancer)
☐ YES ☐ NO
____
Are you currently under a doctor's care for conditions other than the ones you are seeking care for?
☐ YES ☐ NO
____

- **Patient Name: __________________________**
- **Date: _________________________________**

WILSON CO. CHIROPRACTIC

FAMILY HISTORY

Patient Name: ______________________________

Date: ______________________________

Please take a few moments to complete the following. The better you fill it out, the better it will help us treat your condition. Thank you for your cooperation.

Place an "X" in any box that may apply.

	Self	Spouse	Children	Mother	Father	Brother	Sister
Back Pain							
Headaches							
Neck Pain							
Pinched Nerve							
Allergies/Sinus							
Scoliosis							
Arthritis							
Asthma							
Ear Infections							
Cold Hands/Feet							
Carpal Tunnel							