Welcome to Our Practice

Date ________________________

Patient: First Name ___________________________ MI ________ Last _________________________________

Sex M F Date of Birth ____________ Age _______ SS# ______________________ Nickname _______

Street _______________________________________ City _____________________ State _____ Zip __________

Home Tel ___________________ Work Tel ____________________ Ext ________ Email __________________

Occupation ____________________________________ Employer _______________________________________

Marital Status Single Married Divorced Widowed

Spouses Name _________________________________ DOB _____________ Employer ____________________

Referred By _____________________________ Have you ever been a patient of this practice before? Yes No

Family Doctor/ Address ____

In case of emergency, contact: Name ____

Tel # ______________________________ Relationship to Patient _______________________________________

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _______________________ and assign directly to Dr. Willen all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party signature

____ Date ________________

Relationship

Prescription and Nutritional Supplements Form

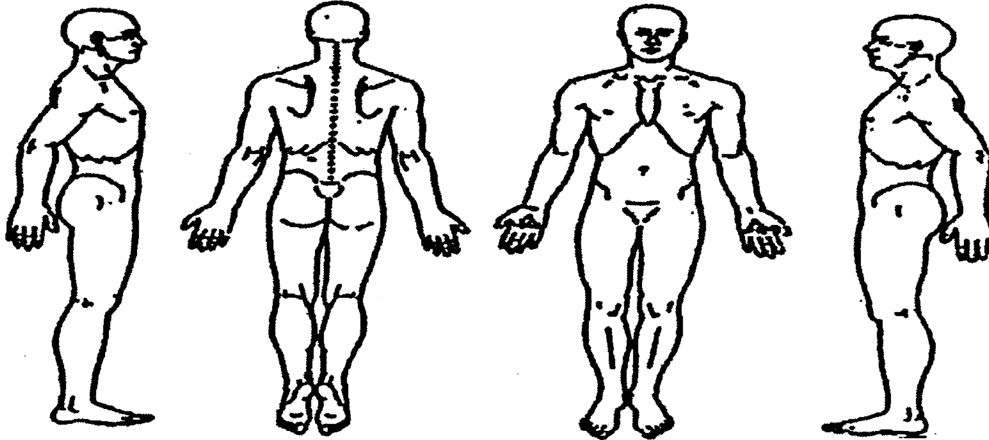
Please list all prescriptions and supplements that you are taking on this form. No need to list elsewhere.

PATIENT INTAKE FORM

Patient Name: ______________________________ Date: ______________

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other ___________

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other:________________

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other:____________
□ Massage Therapist □ Physical Therapist □ No one

10. How long have you had this problem? __________# ___days ___weeks ___months ___years

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

____

14. What concerns you the most about your problem; what does it prevent you from doing?

____

15. What is your: Height___________ Weight _____________ Date of Birth ___________
Occupation ____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependence
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Mononucleosis
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Multiple Sclerosis
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Indigestion
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	□	□ Constipation
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Diarrhea
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Fibromyalgia
□	□ Arthritis	□	□ Hepatitis	□	□ Chronic Fatigue Syndrome
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder	□	□ Ebstien Barr Virus
□	□ Cancer	□	□ General Fatigue	□	□ Yeast Infections
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances	**For Females Only**	
□	□ Chronic Sinusitis	□	□ Dizziness	□	□ Birth Control Pills
□	□ Insomnia	□	□ Forgetfulness	□	□ Hormonal Replacement
□	□ Allergies	□	□ Depression/ Anxiety	□	□ Pregnancy
□	□ Other:____________________				

20. List all prescription medications you are currently taking:
____

21. List all of the over-the-counter medications you are currently taking:
____

22. List all surgical procedures you have had:
____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why ____

26. Have you had significant past trauma? □ No □ Yes _______Emotional _______Physical

27. Anything else pertinent to your visit today?________________________________

Patient Signature________________________________ Date:________________