Dear Patient:

Welcome to our practice! Whether you were referred by a friend or family member or stumbled upon us by chance, we hope to meet all your needs here at Wilkinson Chiropractic Care.

This introductory letter is a rather unconventional way to discuss everyone's favorite topic: fees. We want to make your initial visit as smooth as possible, answering all of your questions and concerns regarding fees before we get started.

Our initial visit fee is $100. This includes your examination, therapies if indicated and your adjustment. Office visits after the initial visit are $52 and include a therapy and an adjustment. If you are filing Medicare, we require an exam and/or x-ray of the main area of complaint, which are $50-$60 and not covered by Medicare. Your spine has been working hard for you for 65+ years and chances are there is a lot of wear and tear on it. If conventional methods of chiropractic adjusting are even to be considered, our assessment must be thorough. We would not be practicing good doctoring if we first did not have a visual of what we were working with. X-rays provide that visual. If you have had x-rays or an MRI of the same area within the last 6 months, we will be happy to view those in place of taking our own films.

If you are a new patient that has had an injury-- fall, twist, crash or accident--it is likely that we will take an x-ray of the area of concern. Again, your safety is our #1 concern and working on an area that is fractured, torn, severely sprained or strained is not to your benefit. Please allow us to care for you in the most effective and conservative manner we are able.

Any additional charges you might incur on this visit that exceed the expected $100 initial visit fee and $50 or $60 x-ray fee will be discussed with you, by the doctor, prior to delivering said service. This applies to any of your office visits. We give you our opinion, you make your decision. Your health care is always in your hands, but we must reserve the right to refuse care if a decision, in our opinion, is not in your best interest. If you have any questions regarding fees or insurance coverage, please direct them to our office manager Sue.

We truly look forward to caring for you and hope that you find great healing under chiropractic care.

In Health,
The Wilkinson Chiropractic Care Team

****Please Read and Initial** _______________

PATIENT NAME: ______________________________

WILKINSON CHIROPRACTIC CARE
DR. RALPH R. WILKINSON   DR. SHERRY L. SHAMP

PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ___/____/____

PATIENT NAME: _______________ _______________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: ________________________________ CITY/STATE: ____________________ ZIP: ___________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (____) ____-_______ YES NO

WORK PHONE #: (____) ____-_______ YES NO

CELL PHONE #: (____) ____-_______ YES NO

E-MAIL: _______________________________ YES NO

WHO IS RESPONSIBLE FOR PAYMENT? _________________________ RELATIONSHIP TO PATIENT? ______________

HAVE YOU HAD CHIROPRACTIC CARE? YES NO LAST CHIROPRACTIC ADJUSTMENT? ______________________

REFERRED BY: ____

INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR MEDICARE? ________________

PRIMARY INSURANCE COMPANY NAME: ____

SECONDARY INSURANCE COMPANY NAME: ____

THE FRONT OFFICE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S).

SOCIAL HISTORY

EMPLOYER: _________________________________ OCCUPATION: _____________________________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

EXERCISE: ☐ NEVER ☐RARE ☐ OCCASIONAL ☐WEEKLY ☐SEVERAL TIMES A WEEK ☐DAILY

TYPES OF EXERCISE: ____

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

NAME OF SPOUSE:___________________________________ NUMBER OF CHILDREN: _______________________

PATIENT NAME: ______________________________

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ SPINAL STENOSIS ☐ RHEUMATOID ARTHRITIS ☐ OTHER ______________________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME ADDRESSING WHAT CONDITION?

____
____
____
____
____
____
____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL FRACTURES, ILLNESSES OR CONDITIONS:

REASON FOR HOSPITALIZATION	DATE

PLEASE LIST ANY ACCIDENTS OR INJURIES:

	DATE

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS ______________________________
☐ OTHER ______________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ACUTE PAIN	Y	N	GOUT	Y	N	OSTEOPENIA	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	OSTEOPOROSIS	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	PREGNANCY	Y	N
BACK TROUBLE	Y	N	HEADACHES	Y	N	RHEUMATOID	Y	N
BLOOD CLOTS	Y	N	HIGH BLOOD PRESSURE	Y	N	STROKE	Y	N
BRONCHITIS	Y	N	JOINT PAIN	Y	N	TMJ ISSUES	Y	N
CANCER	Y	N	LOW BLOOD PRESSURE	Y	N	SLEEP APNEA	Y	N
CHRONIC PAIN	Y	N	MIGRAINE HEADACHES	Y	N	VARICOSE VEINS	Y	N
DIABETES	Y	N	MUSCLE STRAIN	Y	N	OTHER	Y	N

PATIENT NAME: ______________________________

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

______________________________	______________________________
PRINT NAME OF PATIENT, PARENT OR GUARDIAN	SIGNATURE OF DOCTOR
______________________________	______________________________
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT	DATE
______________________________	
SIGNATURE	
______________________________	
DATE	

PATIENT NAME: ______________________________

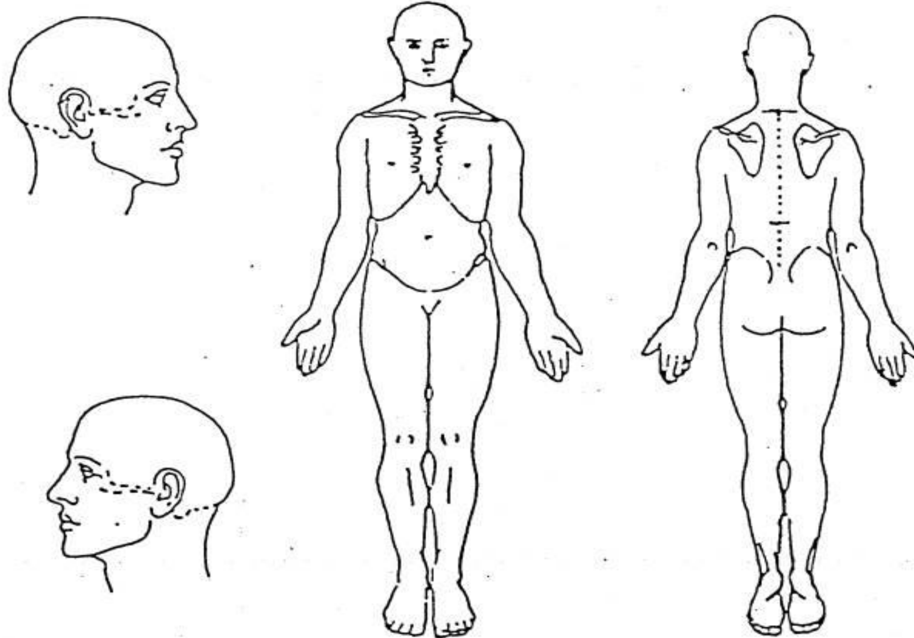
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ______________________________

HAVE YOU HAD THIS CONDITION IN THE PAST? ______ IF YES, WHEN? __________

DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION? _______ IF YES, BY WHOM? ______________________

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ______________________________

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10?
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ RUNNING ☐ OTHER ______________________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ______________________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ______________________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ______________________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO