

# Grant Willis, D.C.

## Patient Information

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Patient Social Security # : \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Single  Married  Divorced  Widowed Children:  No  Yes How Many: \_\_\_\_\_

Drivers License # : \_\_\_\_\_ State Issued: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of primary Care Physician: \_\_\_\_\_

Phone # : \_\_\_\_\_ Fax # \_\_\_\_\_ Is it OK to contact them:  Yes  No

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_

### Insurance Information: Person Responsible for Fees

Name of insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Insured Social Security # : \_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Insurance Plan: \_\_\_\_\_

Policy/ID # : \_\_\_\_\_ Group # : \_\_\_\_\_

Phone # For Claims: \_\_\_\_\_ Website: \_\_\_\_\_

Billing Address For Claims: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Insurance Plan: \_\_\_\_\_

Policy/ID # : \_\_\_\_\_ Group # : \_\_\_\_\_

Phone # For Claims: \_\_\_\_\_ Website: \_\_\_\_\_

Billing Address For Claims: \_\_\_\_\_

**\*\*\*Please provide a copy of your insurance cards and photo ID so we may have a copy on file\*\*\***

Payment for services is due in full at the time of service, including any copays or deductible amounts. It is your responsibility as the patient/responsible party to understand your insurance and what your plan limitations are.

Please feel free to ask questions at any time. Thank your for placing your trust in us.

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Grant Willis, D.C.

## Accident Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What type of accident:  Work Related  Auto  Slip & Fall Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

If work related, was it reported to the employer?  No  Yes – To Whom: \_\_\_\_\_

Have you reported the incident to your insurance?  No  Yes – Carrier's Name: \_\_\_\_\_

Name of the insured: \_\_\_\_\_ Relationship to the insured: \_\_\_\_\_

Billing address for claims: \_\_\_\_\_

Phone # for claims: \_\_\_\_\_ Policy # : \_\_\_\_\_ Claim # : \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Adjuster Phone # : \_\_\_\_\_ Extension: \_\_\_\_\_

Does patient reside with the insured:  No  Yes Does patient own a vehicle in Florida:  No  Yes

Did the accident occur in the state of Florida:  No  Yes If not where: \_\_\_\_\_

Please explain in detail how the accident happened: \_\_\_\_\_

What body parts were injured: \_\_\_\_\_

Have you ever had these complaints before:  No  Yes – When: \_\_\_\_\_

Were you in a relatively good state of health prior to the accident in question:  No  Yes

Is this your first accident:  Yes  No – Explain: \_\_\_\_\_

Have you lost time from work as a result of the accident:  No  Yes – Have you returned:  No  Yes

Did you feel pain immediately after the accident:  No  Yes – Explain: \_\_\_\_\_

Were you rendered unconscious:  No  Yes Were you treated at the accident site:  No  Yes

Did you seek treatment after the accident:  No  Yes – Where: \_\_\_\_\_

What treatment was given:  Exam  X-rays  MRI  Catscan  Other: \_\_\_\_\_

Medications: \_\_\_\_\_

Are you currently under another providers care for this accident:  No  Yes – List: \_\_\_\_\_

### Only Complete If You Have An Auto Related Injury

What type of vehicle were you driving: \_\_\_\_\_ Vehicle Totaled:  Yes  No – Damage \$ \_\_\_\_\_

You were the:  Driver  Front Passenger  Back Seat  Other - \_\_\_\_\_

What direction where you traveling:  North  South  East  West

On which street/intersection: \_\_\_\_\_

On which side were you struck:  Front  Rear  Left  Right  Other - \_\_\_\_\_

What type of vehicle struck you: \_\_\_\_\_

What direction was the other party traveling:  North  South  East  West

On which street/intersection: \_\_\_\_\_

Were the police notified:  No  Yes Is there a police report:  No  Yes – Who was cited? \_\_\_\_\_

# Grant Willis, D.C.

## Patient Review Of Systems & Health History

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Review of Systems			
Please indicate if any of these apply to you over the LAST 3 MONTHS			
<p><b>Constitutional</b></p> <input type="checkbox"/> General good health <input type="checkbox"/> Recent weight change <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Insomnia <input type="checkbox"/> Fever	<p><b>Cardiovascular</b></p> <input type="checkbox"/> Heart trouble <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling of the feet or ankles	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in the stool	<p><b>Neurological</b></p> <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Light headed or dizzy <input type="checkbox"/> Convulsions or seizures <input type="checkbox"/> Numbness or tingling sensation <input type="checkbox"/> Tremors <input type="checkbox"/> Paralysis
<p><b>Eyes</b></p> <input type="checkbox"/> Eye disease <input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Vision loss	<p><b>Respiratory</b></p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing	<p><b>Genitourinary</b></p> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urgency of urination <input type="checkbox"/> Painful urination <input type="checkbox"/> Incontinence	<p><b>Psychiatric</b></p> <input type="checkbox"/> Head injury <input type="checkbox"/> Memory loss <input type="checkbox"/> Fainting <input type="checkbox"/> Poor balance
<p><b>Ears/Nose/Mouth/Throat</b></p> <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Mouth sores <input type="checkbox"/> Swollen glands in the neck <input type="checkbox"/> Bad breath or bad taste	<p><b>Hematological</b></p> <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Anemia <input type="checkbox"/> Recurrent infections	<p><b>Musculoskeletal</b></p> <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Weakness of muscles or joints <input type="checkbox"/> Muscle pain or cramps <input type="checkbox"/> Back pain <input type="checkbox"/> Difficulty walking	<p><b>Skin</b></p> <input type="checkbox"/> Nervousness <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Sleep problems <input type="checkbox"/> Rash or itching <input type="checkbox"/> Change in skin color <input type="checkbox"/> Change in hair or nails
<p><b>Endocrine</b></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Glandular or hormone problems			

Health History			
Please indicate if any of these HAVE EVER applied to you (Y) or your family (F)			
<input type="checkbox"/> Y <input type="checkbox"/> F Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> F Hives or eczema	<input type="checkbox"/> Y <input type="checkbox"/> F Mono	<input type="checkbox"/> Y <input type="checkbox"/> F Metal implants
<input type="checkbox"/> Y <input type="checkbox"/> F Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> F Hepatitis A, B or C	<input type="checkbox"/> Y <input type="checkbox"/> F Mumps	<input type="checkbox"/> Y <input type="checkbox"/> F Swollen ankles
<input type="checkbox"/> Y <input type="checkbox"/> F Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> F Asthma	<input type="checkbox"/> Y <input type="checkbox"/> F Chickenpox	<input type="checkbox"/> Y <input type="checkbox"/> F Sinusitis
<input type="checkbox"/> Y <input type="checkbox"/> F Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> F Cancer	<input type="checkbox"/> Y <input type="checkbox"/> F Whooping cough	<input type="checkbox"/> Y <input type="checkbox"/> F Colitis
<input type="checkbox"/> Y <input type="checkbox"/> F Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> F Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> F Scarlet fever	<input type="checkbox"/> Y <input type="checkbox"/> F Epilepsy
<input type="checkbox"/> Y <input type="checkbox"/> F Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> F HIV / AIDS	<input type="checkbox"/> Y <input type="checkbox"/> F Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> F Pregnant
<input type="checkbox"/> Y <input type="checkbox"/> F Measles	<input type="checkbox"/> Y <input type="checkbox"/> F Kidney disease	<input type="checkbox"/> Y <input type="checkbox"/> F Anemia	<input type="checkbox"/> Y <input type="checkbox"/> F Blood or plasma transfusions
<input type="checkbox"/> Y <input type="checkbox"/> F Stroke	<input type="checkbox"/> Y <input type="checkbox"/> F Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> F Bladder infection	<input type="checkbox"/> Y <input type="checkbox"/> F High blood pressure
<input type="checkbox"/> Y <input type="checkbox"/> F Heart attack	<input type="checkbox"/> Y <input type="checkbox"/> F Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> F Migraine headaches	<input type="checkbox"/> Y <input type="checkbox"/> F Low blood pressure
<input type="checkbox"/> Y <input type="checkbox"/> F Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> F Mental/Psychiatric disorder	<input type="checkbox"/> Y <input type="checkbox"/> F Hernia	<input type="checkbox"/> Y <input type="checkbox"/> F Heart Attack

Please list previous hospitalizations/surgeries/serious illnesses (please explain): \_\_\_\_\_

Please list all **ALLERGIES**: \_\_\_\_\_

Please list any medications that you take (prescription and over-the-counter): \_\_\_\_\_

Do you exercise?  Never  Rarely  Moderately  Daily Type: \_\_\_\_\_

Use of Caffeine:  Never  Rarely  Moderately  Daily Comments: \_\_\_\_\_

Use of Alcohol:  Never  Rarely  Moderately  Daily Comments: \_\_\_\_\_

Use of Tobacco:  No  Yes – Packs/day: \_\_\_\_\_ Previously, but quit: (date) \_\_\_\_\_

Use of Drugs:  Never  Rarely  Moderately  Daily Type: \_\_\_\_\_

# Grant Willis, D.C.

## Patient Symptom Survey

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### PLEASE CHECK ALL THAT APPLY

**Headaches** How often do they occur:  Constant  Daily  Weekly  Monthly  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Location:  Forehead  Back of Head  Temples  Left Side  Right Side  Behind The Eyes  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Jaw Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Neck Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
The pain is increased by:  Forward Motion  Left Rotation  Bending To The Left  
 Backward Motion  Right Rotation  Bending To The Right  
The pain radiates into:  Shoulders ( Left / Right )  Arms ( Left / Right )  Hands ( Left / Right )  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Mid Back Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Low Back Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
The pain radiates into:  Buttocks ( Left / Right )  Legs ( Left / Right )  Feet ( Left / Right )  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Shoulder Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Patient Symptom Survey (Page 2)**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Elbow Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Wrist / Hand Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Hip / Pelvis Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Knee Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Ankle / Foot Pain** Location:  Bilateral  Left  Right Cause: \_\_\_\_\_  
How would you rate the pain: **None** 1 2 3 4 5 6 7 8 9 10 **Severe**  
Any associated:  Muscle Spasms  Stiffness  Grinding  Clicking  Numbness  Tingling  
Have you seen any doctors for this complaint?  No  Yes  
If "Yes" : Doctor: \_\_\_\_\_  
Treatment: \_\_\_\_\_

Please list any other problems you are having as a result of this injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Briefly describe your daily activities have changed due to this injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_