

**Dr. Don Williams, D.C. - Vibrant Living Center**

**Patient Personal History**

Email: \_\_\_\_\_

Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Business/Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_

Check One:  Married  Single  Widowed  Divorced  Separated # of Children: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

Who is responsible for your bill:  Self/Spouse  Workers Comp  Medicare  Insurance  Personal Health Insurance / Other: \_\_\_\_\_

**Current Health Condition**

Purpose of this appointment: \_\_\_\_\_

Other doctors seen for this condition? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ If disabled from work, please give date: \_\_\_\_\_

Drugs you take now:  Nerve Pills  Pain Killers/Muscle Relaxers  Blood Pressure Medicine  
 Insulin  Other \_\_\_\_\_

**Past Health History**

**Please check or describe:**

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  Hernia  
 Broken Bones Other: \_\_\_\_\_

Major Accidents or Falls: \_\_\_\_\_

Hospitalization (Other than above): \_\_\_\_\_

Previous Chiropractic Care – Doctor’s Name and Approximate Date of Last Visit: \_\_\_\_\_

Have you been treated for any health condition in the last year?  Yes  No If Yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_



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### Statement of Intent

Our primary goal for your care is to help you achieve vibrant health by addressing the cause of your condition. Our evaluation will determine how your body is functioning. Through gentle hands-on care and education, interference is removed and balance is restored. As you become more aware of your Self and body, your perception of the powerful Innate Intelligence within you will strengthen, supporting you to make positive changes in your life. This Intelligence is what guides our bodies through its daily actions, including the healing process. We share our goal so you may understand it and the means by which it is attained.

Symptoms are not necessarily a sign of ill health. Quite frequently they are needed to get our attention; something needs to change; a pattern is ready to be released. Alternatively, the disappearance of symptoms does not necessarily equate with improved health. Often as we heal and become more aware of our bodies, we may experience the symptoms that we previously ignored. For this reason, as the healing process unfolds, more may be revealed and a treatment plan is created to address your whole being. We are excited to share in your healing.

Please realize that we do not diagnose any ailment or diseases. We encourage any individual having concerns about symptoms or disease to consult his or her medical doctor at any time during chiropractic care.

### Consent to Care

I, \_\_\_\_\_, have read the above, understand it fully and choose to receive chiropractic care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian if a minor: \_\_\_\_\_

### Payment Agreement

I understand that a fee for services rendered at The Vibrant Living Center will be charged and I am responsible for this fee. I also understand that any sum of money paid under assignment by any insurance will be credited to my account and I am responsible for any and all of the unpaid balance. If I choose to suspend or terminate care, I understand that all fees for services rendered at The Vibrant Living Center are due and payable at that time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian if a minor: \_\_\_\_\_

### Cancellation Policy

If you are unable to make your appointment, we ask that you give 24 hours notice. This advanced notice is greatly appreciated. It frees the time for individuals seeking acute care and allows the doctors to serve others more effectively. We will gladly reschedule your appointment. If you choose not to give this notice, a \$20 fee will be due at your next appointment.

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Name \_\_\_\_\_

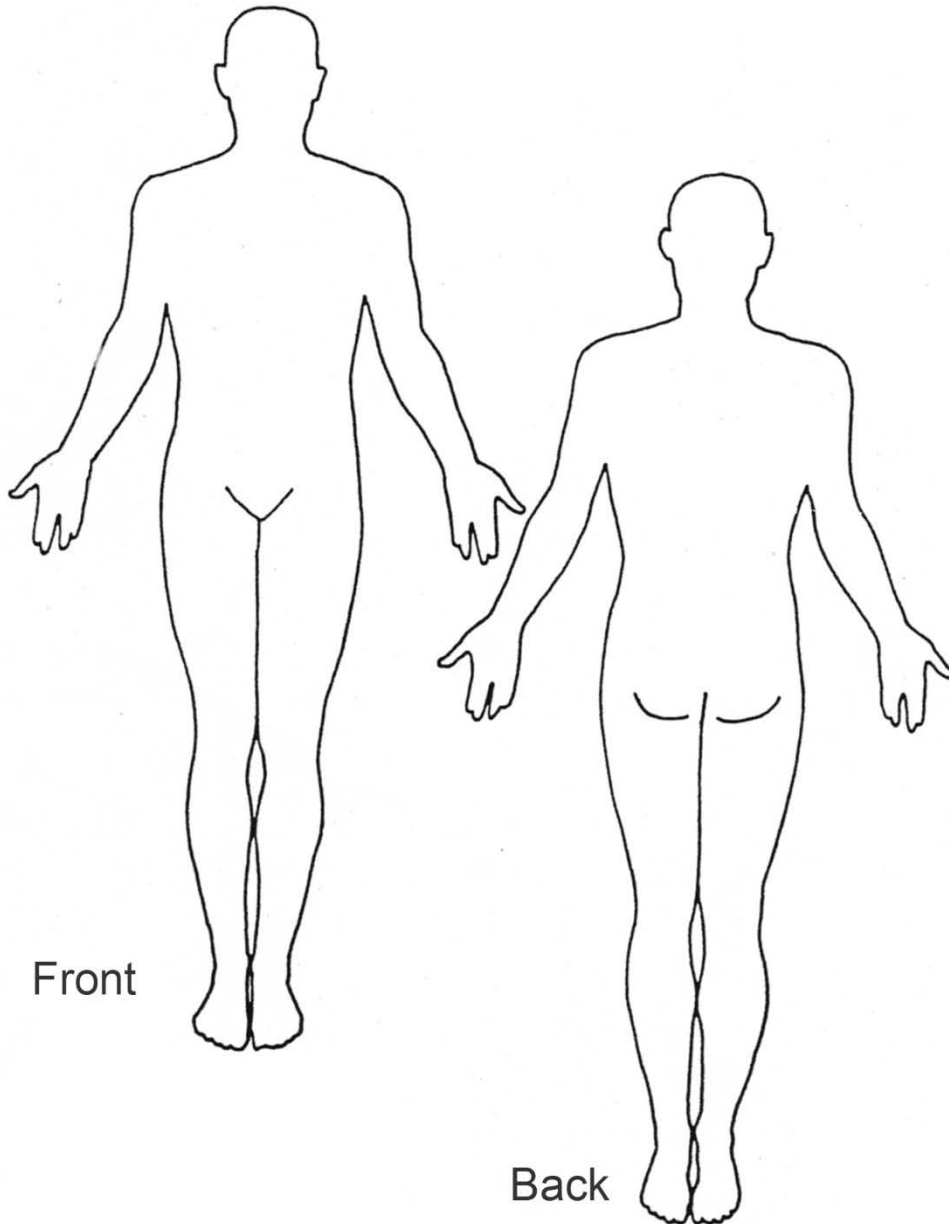
Date \_\_\_\_\_

**PAIN DRAWING**

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing.

Sharp and stabbing = ++++  
Pins and Needles = 0000

Dull and achy = VVVV  
Numbness = ///



Pain Scale:  
Back 0 ————— 10      Leg 0 ————— 10