

# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_  
SS/HIC/Patient ID # \_\_\_\_\_  
Patient Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
E-mail \_\_\_\_\_  
Sex  M  F Age \_\_\_\_\_  
Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years  
Occupation \_\_\_\_\_  
Patient Employer/School \_\_\_\_\_  
Employer/School Address \_\_\_\_\_  
Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
SS# \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_  
Is patient covered by additional insurance?  Yes  No  
Subscriber's Name \_\_\_\_\_  
Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_  
Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)  
Dr. \_\_\_\_\_ 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

## PHONE NUMBERS

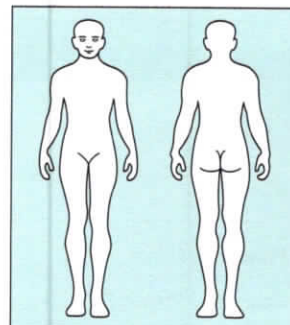
Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
**IN CASE OF EMERGENCY, CONTACT**  
Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No  
Date \_\_\_\_\_  
Type of accident  Auto  Work  Home  Other  
To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker Comp.  Other  
Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_  
When did your symptoms appear? \_\_\_\_\_  
Is this condition getting progressively worse?  Yes  No  Unknown  
Mark an X on the picture where you continue to have pain, numbness, or tingling.  
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_  
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other  
How often do you have this pain? \_\_\_\_\_  
Is it constant or does it come and go? \_\_\_\_\_  
Does it interfere with your  Work  Sleep  Daily Routine  Recreation  
Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy

Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_

Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_

Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other _____		
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
						Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

### EXERCISE

- None
- Moderate
- Daily
- Heavy

### WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

### HABITS

- Smoking \_\_\_\_\_ Packs/Day \_\_\_\_\_
- Alcohol \_\_\_\_\_ Drinks/Week \_\_\_\_\_
- Coffee/Caffeine Drinks \_\_\_\_\_ Cups/Day \_\_\_\_\_
- High Stress Level \_\_\_\_\_ Reason \_\_\_\_\_

Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

### MEDICATIONS

### ALLERGIES

### VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____



# VEHICLE ACCIDENT INFORMATION

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_  a.m.

p.m.

Please describe the accident in your own words: \_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian

How many people were in the accident vehicle? \_\_\_\_\_

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_

City/State \_\_\_\_\_

Nearest intersection with road/street \_\_\_\_\_

Driving conditions  Dry  Wet  Icy  Other \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_

Speed you were traveling? \_\_\_\_\_

## IMPACT

Did your car impact another vehicle?  Yes  No

Did your car impact a structure?  Yes  No

If yes, explain \_\_\_\_\_

Did any part of your body strike anything in the vehicle?

Yes  No If yes, explain \_\_\_\_\_

Was impact from :

Front  Rear  Left  Right  Other \_\_\_\_\_

At the time of impact were you:

Looking straight ahead  Looking to the right

Looking to the left  Looking down

Looking up

Were both hands on the steering wheel?  Yes  No

If no, which hand was on the wheel?  Right  Left

Was your foot on the brake?  Yes  No

If yes, which foot was on the brake?  Right  Left

Were you:  Surprised by impact  Braced for impact

## VEHICLE

Make and model of vehicle you were in: \_\_\_\_\_

Were you wearing a seatbelt?  Yes  No

If yes, what type?  Lap  Shoulder

Was vehicle equipped with airbags?  Yes  No

If yes, did it/they inflate properly?  Yes  No

Did your seat have a headrest?  Yes  No

If yes, what was the position of the headrest?

Low  Midposition  High

## OTHER VEHICLE

(if applicable)

Make and model of other vehicle \_\_\_\_\_

Which direction was other vehicle headed? \_\_\_\_\_

Speed other vehicle was traveling \_\_\_\_\_

## POLICE

Did the police come to the accident site?  Yes  No

Were there any witnesses?  Yes  No

Was a police report filed?  Yes  No

Was a traffic violation issued?  Yes  No

If yes, to whom? \_\_\_\_\_

## PATIENT CONDITION

Were you unconscious immediately after the accident?  Yes  No If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident:

## TREATMENT

Did you go to the hospital?  Yes  No

When did you go?  Immediately after accident  Next day  2 days or more after the accident

How did you get to the hospital?  Ambulance  Private transportation

Name of hospital \_\_\_\_\_ Name of doctor \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment received \_\_\_\_\_

X-rays taken \_\_\_\_\_

## SYMPTOMS/INJURIES

Have you been able to work since this injury?  Yes  No How many work days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No

If you have had any of the following symptoms since your injury, please  check:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff          |
| <input type="checkbox"/> Back stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear buzzing       | <input type="checkbox"/> Leg pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear ringing       | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Vision blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

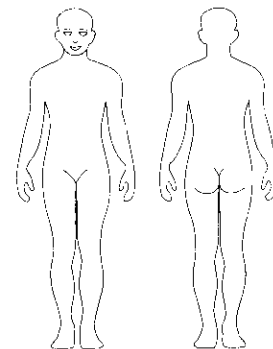
Type of pain:  Sharp  Dull  Throbbing  Numbness  
 Aching  Shooting  Burning  Tingling  
 Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Movements that are painful to perform:  Sitting  Standing  Walking  
 Bending  Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Dr. Darren T Woodling  
Family Chiropractic

200 Elba Hwy  
Troy, AL 36079  
(334)566-5295 Phone  
(334)566-9821 Fax

---

**Authorization and Assignment**

I authorize Dr. Woodling to examine, take x-rays, treat me and do whatever they deem necessary in accordance with the states statutes for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between the insurance company and me. Furthermore, I understand the Dr. Woodling will prepare any necessary reports and forms to assist me in making a collection from the insurance company and that any amount authorized to Woodling Chiropractic will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination, prognosis and treatment records to my employers, attorney or insurance company.

**Agreement to pay: The undersigned accepts the fee charged as a lawful debt and promises to pay the said fee including the cost of collection, attorney fees and court cost if necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state.**

Patient Signature: \_\_\_\_\_

Patient Name (Printed): \_\_\_\_\_

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

**\*\*Flip over to sign second release form\*\***

# INFORMED CONSENT FOR CHIROPRACTIC CARE

WOODLING CHIROPRACTIC  
& WELLNESS CENTER  
220 ELBA HWY  
TROY, AL 36079  
334-566-5295 PHONE  
334-566-9821 FAX

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please discuss any questions or concerns with the doctor before signing the consent. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by the doctor and staff of Woodling Chiropractic.

I have had the opportunity to discuss with the doctor and/or staff the purpose and benefits of the chiropractic adjustment and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problems I understand and am informed that there are some risk involved with the treatment. Risk include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

## X-RAYS, SPINAL MANIPULATION (ADJUSTMENTS) AND THERAPIES

I understand that chiropractic care is not an exact science and therefore reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction and I am consenting to the proposed treatment.

\_\_\_\_\_  
Signature of patient, parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of patient, parent or legal guardian

\_\_\_\_\_  
Relationship to Patient

**PATIENT RECORDS AND DOCTOR'S LIEN**

TO: ATTORNEY/INSURANCE CARRIER

WOODLING CHIROPRACTIC  
&WELLNESS CENTER  
220 ELBA HWY  
TROY, AL 36079  
334-566-5295

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier, with a full report of my case history, examination, diagnosis, treatment and prognosis of myself in regard to my accident/injury which occurred/began on or about: \_\_\_\_\_ (date of accident/injury).

I hereby give a lien to said provider on any settlement, judgment or verdict as a result of said accident/injury and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums as may be due and owing Woodling Chiropractic for their services rendered to me and withhold such sums from said settlement, claim, judgment or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by Woodling Chiropractic for any and all services rendered to me and that this agreement is made solely for said provider's additional protection and in consideration of Woodling Chiropractic's waiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which Woodling Chiropractic may recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment for my account. Also that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 5% per month service charge.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately the above named provider.

**Attorney's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please sign and return this copy to our office via fax (334-566-9821) or email  
(woodlingchiro@gmail.com) and retain a copy for your records.