Fairfield Chiropractic
Paul A. Willmon, DC
Lacie Legros, DC
Phone: (281) 256-8100
Fax: (281) 256-8163

Welcome to Fairfield Chiropractic

Please take a few minutes to fill out these pages in their entirety to help us care for your needs.

Name ________________________________ Sex M F Date ____________________________

Address___________________________________ City_______________ State____ Zip ___________

Phone (Home) _________________ (Cell) _________________ (Work) __________________

Date of Birth ___/___/_____ Age ______ Emergency phone #: ______________________________

Marital Status: ____________________ Email address: _____________________________________

Occupation _____________________________ Employer: ____________________________________

Have you ever received chiropractic care? Y N If yes, when? _______________________________

1. **Primary Reasons for seeking chiropractic care:**

   a. Chief Complaint:____

   Location of complaint: ____

   Complaint began when and how? ____

   Please circle the quality of the chief complaint/pain:

   Dull Ache Sharp Shooting Burning Throbbing Deep Nagging Other ________________

   Does this complaint/pain radiate (shoot) to any areas of your body? Y N Where? _______________

   Do you have any numbness or tingling in your body? Y N Where? __________________________

   Grade the intensity/severity of your complaint/pain. Circle the number that best represents your pain.

   (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

   How frequently is pain present? 0-25% 26-50% 51-75% 76-100% of the day

   What activities/positions make the pain worse? ____

   What activities/positions make the pain better? ____

   What activities are you unable to do or less able to do because of this condition? ________________

   ____

   b. Secondary Complaint (if any):____

   Location of complaint:____

   Complaint began when and how? ____

2. **Previous interventions, treatments, medications, surgery, or care you have sought for your complaint:** ____

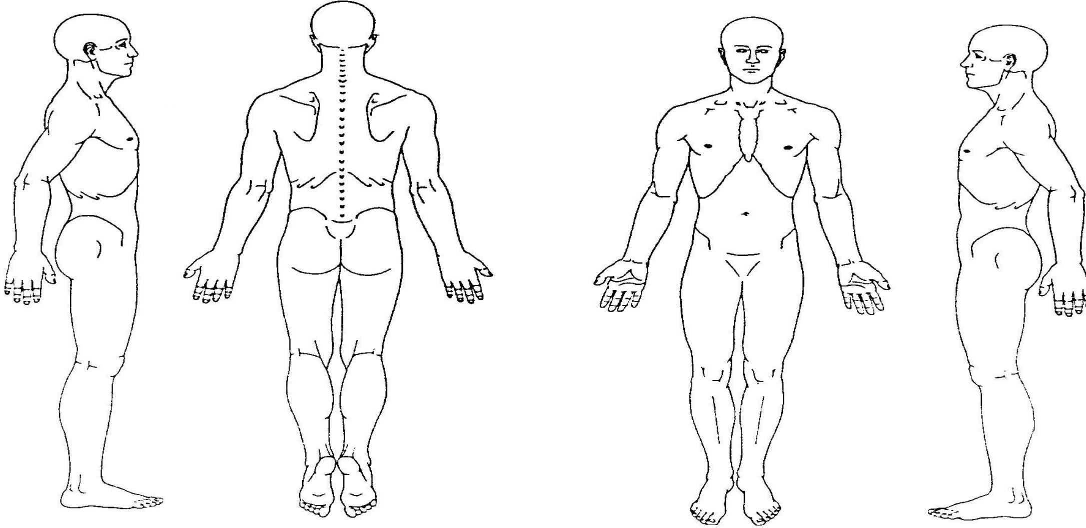
   ____

   ____

Fairfield Chiropractic
Paul A. Willmon, DC
Lacie Legros, DC
Phone: (281) 256-8100
Fax: (281) 256-8163

Please be sure to fill this out accurately. Use the letters to mark the type of sensations you are currently experiencing on the drawing below.

A= Aching pain | B=Burning pain | S=Stabbing/sharp pain
P=Pins and Needles (Tingling) | N=Numbness | O= Other sensations



3. **Past Health History:**

a. Previous illnesses you have had in your life: ____________________

____

b. Previous injury or trauma: ____________________

____

Have you ever broken any bones? Which? ____________________

____

c. Allergies ____________________

d. Medications:

Medication	Reason for taking
____________________	____________________
____________________	____________________
____________________	____________________

e. Surgeries:

Type of Surgery	Date
____________________	____________________
____________________	____________________
____________________	____________________

Fairfield Chiropractic
Paul A. Willmon, DC
Lacie Legros, DC
Phone: (281) 256-8100
Fax: (281) 256-8163

f. Females: Pregnancies and Outcomes

Pregnancy/Date of Delivery	Outcome (natural, c-section, complications)
______________________	______________________
______________________	______________________
______________________	______________________

4. Family Health History

Health problems of self/relatives

○ High blood pressure ○ Heart problems ○ Cancer ○ Diabetes ○ Stroke
○ Multiple Sclerosis ○ Headaches ○ Liver ○ Stomach ○ Lungs
○ Reproductive system (male/female) ○ Gall bladder ○ Kidneys ○ Colon

Deaths in immediate family (parents/siblings):

Relation and cause of death	Age at death
______________________	______________
______________________	______________
______________________	______________

5. Social and Occupational History

a. Level of Education: ○ High school ○ Some college ○ College graduate ○ Post-graduate studies
b. Job Description: ______________________________
c. Work Schedule: ______________________________
d. Recreational activities: ______________________________
e. Lifestyle (hobbies; level of exercise; use of alcohol, tobacco, drugs; diet): ______________
____

6. Additional comments or information you would like to provide.

____
____
____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care, in accordance with the statutes of the state of Texas.

Patient's Signature ______________________________ Date: ______________