

WELCOME TO WATKINS FAMILY CHIROPRACTIC...

WE ARE GLAD TO MEET YOU!

We are glad you are coming in for a wellness check up. Many of our patients visit us to help with a specific symptom or health concern. We strive to help them reach their health goals. However, most of our patients come in without symptoms! They visit the chiropractor periodically to maximize their performance and prevent problems from arising.

OUR PROMISE

At Watkins Family Chiropractic, your health and welfare are our main concern. Our team will be your personal host, guiding you each step of the way.

CONSULTATION

During the consultation, Dr. Watkins will sit down with you to discuss your health goals and any pertinent health history.

EVALUATION

Following the consultation, Dr. Watkins will perform a thorough chiropractic evaluation. We use the latest technology to figure out exactly what is going on.

X-RAYS

When required, x-rays will be taken to get a closer look at the potential cause of a problem.

You are encouraged to ask questions from Dr. Josh or anyone on the Watkins Family Chiropractic team. Our goal is to make your visits to our clinic the most effective, efficient, enjoyable health care experience you could have on your road to better health.

Sincerely,

DR. JOSH WATKINS
KELLY SCHMITT
MARY ELMER
PATTI STREFF
BEN GRAMS
JENNINE MORGAN





Watkins Family Chiropractic

6001 Egan Drive · Savage 952.440.4553

Name _____ Birth date ___/___/___

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work # _____

Cell # _____ E-mail _____

Employer _____ Type of work _____

Marital Status Mar. Sing. Div. Wid. Type of insurance _____

How many children do you have? _____ Emergency Contact _____

Names _____ Age _____ Relationship _____

_____ Employer _____

_____ Phone # _____

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes No Reason for those visits? _____

Previous Chiropractor's Name _____ Approximate Date of Last Visit _____

REASON FOR THIS VISIT

Please describe the purpose of this visit _____

Is the purpose of this appointment related to:

- Wellness Check-up Chronic Discomfort Fall Home Injury Job Auto Sports Daily Life

Please explain: _____

If job related, have you made a report of your accident to your employer? Yes No

When did this health challenge begin? _____

Has this gotten worse stayed constant
 comes and goes

Does this interfere with Work Sleep
 Daily Routine Other Activities

Explain _____

Has this condition occurred before? Y N

Explain _____

Have you seen other professionals for this?
 Yes No

Dr.'s Name (s) _____

Type of Treatment _____

Results _____

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for preventative maintenance. Please check the type of care desired.

- Relief Care**—Symptomatic relief of pain or discomfort
 Corrective Care—Correcting and relieving the cause of the problem as well as the symptoms
 I want the Doctor to select the type of care appropriate for my condition.

Medications

- Stomach Medications Stimulants
 Pain Killers (including aspirin) Blood Thinners
 Muscle Relaxers Prozac or similar
 Blood Pressure Hormone Therapy
 Insulin _____

Wellness

How long has it been since you really felt well?

When were you last on a wellness program?

Health Conditions

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and the possibility of being accepted for care.

- | | | |
|--|--|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart surgery/pacemaker | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pain between the shoulders | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Numbness or pain in arms/legs/hands | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Ulcers/colitis | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Carpal Tunnel |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Smoking/tobacco use | _____ |
| | | _____ |

For Women:

- Are you pregnant? Yes No
 Are you nursing? Yes No
 Are you taking birth control? Yes No
 Do you experience painful periods? Yes No
 Do you have irregular cycles? Yes No

Childhood Years

- | | No | Yes | Explain: |
|---|--------------------------|--------------------------|----------|
| 1) Stress during your childbirth (forceps, c-section premature delivery, dislocated shoulder/hip) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2) Any falls or injuries? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3) Allergy/Asthma or Respiratory problems? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4) Ear Infections? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5) Digestive Problems? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6) Hyperactivity? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7) Any other health related problems? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Adult Years

- | | No | Yes | Explain: |
|--|--------------------------|--------------------------|----------|
| 1) Accidents? (sports, work, auto) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2) Stress? (work, family, home) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3) Hospitalizations/Surgeries? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4) Major Illnesses? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5) Reoccurring Illnesses? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6) Limited Exercise? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7) Others? (poor nutrition, limited exercise, ↓ sleep) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Authorization

The statements made on this form are accurate to the best of my recollection, and I agree to allow this office to examine me for further evaluations. If I decide to receive care here, I hereby authorize the Doctor(s) to work with my condition through the use of adjustments as he or she deems appropriate. I clearly understand and agree that all services rendered to me are my financial responsibility. I understand that health and accident insurance policies are an arrangement between myself and an insurance carrier. The office does work with insurance companies directly by submitting forms, claims, and notes for reimbursement on behalf of the patient; the amounts authorized to be paid directly to the Doctor's Office will be credited to my account on receipt from insurance companies. In the event that an account becomes delinquent and a collection agency and/or law office is needed to collect on the account, the patient is responsible for all collection costs and/or attorney fees.

Patient or Guardian Signature: _____ Date: _____

WATKINS FAMILY CHIROPRACTIC

FAMILY HEALTH HISTORY

Please check each of the health conditions that a family member has now or has had in the past. Next to any box checked, please indicate the family member(s) affected by the condition. Do this by inserting the letter associated with the family member from the box below.

- A. Grandfather
- B. Grandmother
- C. Father
- D. Mother
- E. Aunt/Uncle
- F. Sibling(s)
- G. Spouse
- H. Child

- | | | |
|--|---|---|
| <input type="checkbox"/> Severe or frequent headaches | <input type="checkbox"/> Irregular Bowel | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies/Sinus Congestion | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart disease/Heart attack | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pain between the shoulders | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Frequent neck pain | <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Numbness or pain in arms/legs/hands | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Lower back problems | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Digestive problems/Colic | <input type="checkbox"/> Asthma | <input type="checkbox"/> Car accident |
| <input type="checkbox"/> Ulcers/colitis | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Sports/Work Injury |
| | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Other |
| | <input type="checkbox"/> ADHD | _____ |
| | <input type="checkbox"/> Shingles | _____ |

Patient name: _____

Patient signature: _____ Date _____