Dr. William F. Winters
Chiropractor

2682 Willoughby Blvd, Ste 1
Stuart, FL 34994

Welcome to Winters Family Chiropractic

Please Print Clearly and Fill In Completely

Print Name_____ **Email**_____

Street Address_____ **Phone**_____

City_____ **State**_____ **Zip**_____ **Date of Birth**_____

Please Check Sex: Male Female Right handed Left handed Married Single

HealthHistory:

Give reason for seeking chiropractic care:_____

Describe any health problems, including how long you've had them:_____

Are you under the care of any other doctor? Yes No
If Yes, the conditions being treated for:

List any current Medications:_____

List any past surgeries & dates:_____

List any past accidents & dates:_____

List any x-rays you've had in the past 2 years:

Personal&FamilyHistory:

Your Occupation:_____ Work Duties_____

Spouse's health status_____

Children's ages and health status:

ChiropracticHistory:

Have you ever been to a Chiropractor before? Yes No If yes Doctor's Name_____

Date of last chiropractic visit_____ Reason for care_____

Date of last chiropractic x-rays_____ How long were you under care?_____

Are other family members under chiropractic care? - Yes NoWho?

WellnessCommitment

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%--------20%--------30%--------40%--------50%--------60%--------70%--------80%--------90%--------100%

Where did you hear about our clinic, or who referred you? _____

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FEMALES: ***Please Check One*** Is there a possibility of you being pregnant? **Yes** **No**

If you have had the following, or if you suffer from the following

Please Check:

Condition, Symptom, or Problem	***Consistently or Frequently***	***Sometimes or Occasionally***
Headache		
Migraines		
Neck Pain		
Shoulder Pain		
Arm/Hand Pain		
Mid Back Pain		
Low Back Pain		
Hip Pain		
Leg/Foot Pain		
Disc Problems		
Arthritis		
Other Joint Pain		
Numbness		
Joint Swelling		
Dizziness		
Nausea		
Weakness		
Fatigue		
Nervousness		
Insomnia		
Heart Problems		
Frequent Colds		
Nose Bleeds		
Ringing in Ears		
Earaches		
Hearing Loss		
Cough		
Chest Pains		
Female Problems		
Allergies		
Asthma		
Cancer		
Osteoporosis		
Diabetes		

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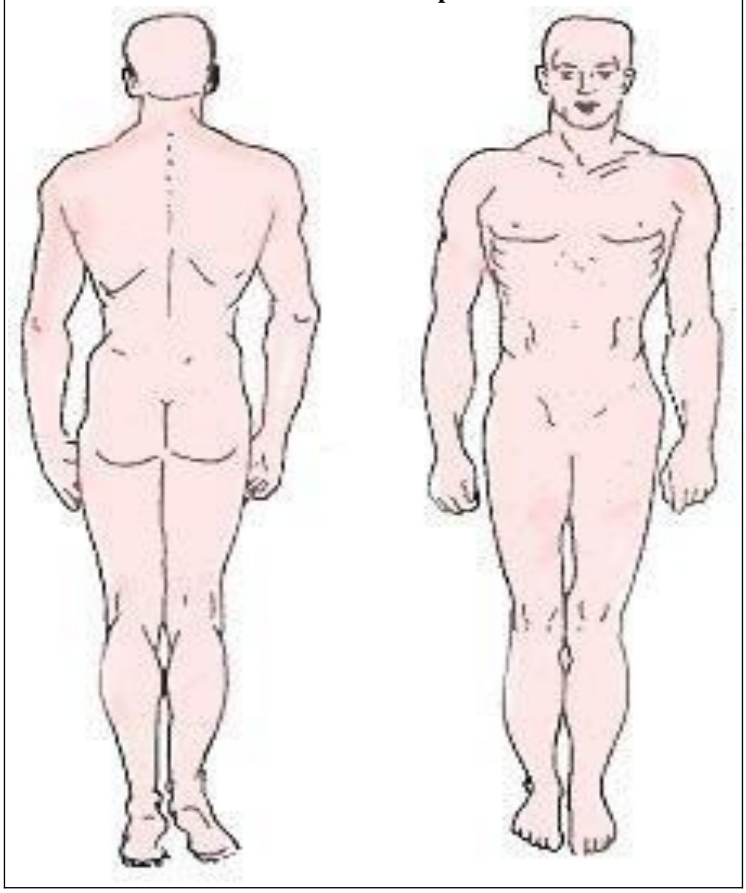
Hypoglycemia		
Digestive Problems		
Urinary Problems		
Skin Conditions		
Other		

Click the areas where you have any problem.
Please also describe these problems.



Below, please fill in any other health information you feel we might need for your care:

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough

Please Sign: _____ **Date:** _____