

Welcome

And thank you for choosing **Touch Healing Arts**

Patient Information

Today's Date: _____

Name: _____

Prefer to be called: _____ Male Female

Address: _____

City _____ State _____ Zip _____

SS#: _____ DL#: _____

Birthdate: _____ Age: _____ # Children: _____

Single Married Divorced Separated Widow

Employer: _____

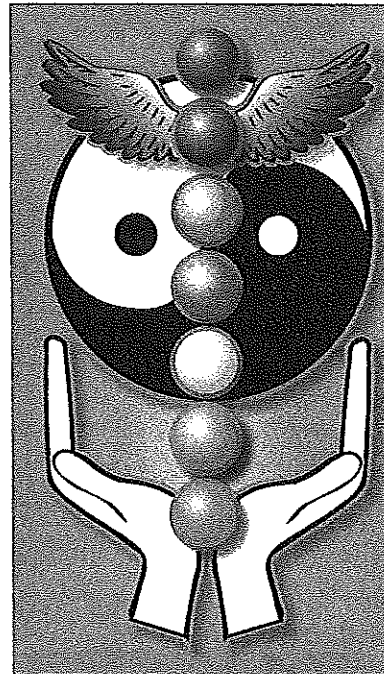
Employer Address: _____

Spouse's/Partner's Name: _____

Birthdate: _____ SS#: _____

Spouse's Employer: _____

How did you hear about us?: _____



Contact Information

Home Phone: _____ Cell: _____ Work Phone: _____ Extension: _____

Email Address: _____ May we confirm appointments by email? Yes No

In case of emergency contact:

Name: _____ Relationship: _____ Home Phone: _____ Work: _____

Patient Condition

Your Present Complaint: _____

When did your condition begin? _____

Is condition due to an accident? No Yes, Auto Yes, Work Yes, Other

If so, what was the date of the accident? _____

When is your pain at its worst? _____

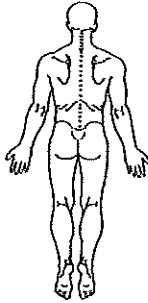
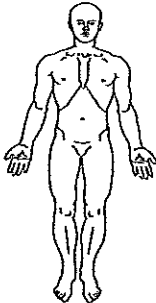
How often do you have this pain? _____ % of the time.

Does your pain Interfere with your Work Sleep Daily Routine Recreation

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

Describe your pain (mark all that apply) Sharp Dull Throb Numb Ache Burn Tingle Stiff

Mark X where you feel pain/problem

Health History

Why this Form is Important

A thorough and accurate health history is essential for the best treatment for your condition. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most time the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Other health professional seen for your condition (please list):

Chiropractor _____ Results: _____
 Medical Doctor _____ Results: _____
 Other _____ Results: _____

Date of Last: Physical Exam _____ Spinal Exam _____ Spinal X-Ray _____
 Blood Test _____ Urine Test _____ MRI/CT Scan _____

Place an X to indicate if you have had any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Fractures | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Headache | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Numbness | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pins and Needles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Vaccine Reaction |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |

Activities

- | | | |
|---------------------------------------|--------------------------------------|---|
| Exercise | Work | Habits |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Sitting | <input type="checkbox"/> Smoke _____/day |
| <input type="checkbox"/> Frequently | <input type="checkbox"/> Standing | <input type="checkbox"/> Alcohol _____/week |
| <input type="checkbox"/> Periodically | <input type="checkbox"/> Light Labor | <input type="checkbox"/> Caffeine _____/day |
| <input type="checkbox"/> None | <input type="checkbox"/> Heavy Labor | <input type="checkbox"/> High Stress Level |

Injuries/Surgeries

Falls: _____
 Head Injuries: _____
 Dislocations: _____
 Surgeries: _____
 Broken Bones: _____
 Serious Illness\Injury: _____

Medications

Please list any medications you take: _____

Please list any supplements/herbs you take: _____

This office requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager. If my account is not paid within 90 days from date of service and no other arrangements have been made, I understand I will be responsible for any expenses incurred in collecting my account.

I understand the information in this form and guarantee it was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my address, insurance, or medical status.

Patient Signature _____ **Date** _____

Dr. Wil R. McCauley, P.A. -----Touch Healing Arts
609 SW 8th Street, Suite 600 Bentonville, AR 72712 ph# (479) 286-1133

Report of Findings - Informed Consent

Dear Patient:

You have a right, as a patient, to be informed about your condition and the recommended chiropractic adjustments and other chiropractic procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

In the practice of chiropractic there are some risks to examination and treatment procedures including, but not limited to, fractures, disc injuries, dislocations, sprains and increased symptoms and pain, or no improvement of the symptoms or pain. A rare but serious risk associated with neck manipulation is stroke.

The Doctor of Chiropractic is not able to anticipate and explain all risks and complications but relies on clinical judgment based on all the facts known at the time of the procedure, and makes decisions that according to the facts available, are to the best interest of the patient . There are no guaranties or assurances concerning the intended results of the treatments

The results of the examination I received at Dr. Wil R. McCauley, P.A./Touch Healing Arts have been explained to me. I understand the results of the examination, the proposed plan of care and the possible risks associated with the treatment. I understand that my care will be rendered by Dr. Wil R. McCauley working under the State of Arkansas license # 15716. I also understand the cost of the treatment proposed.

I have read and understand the statements written in this form. I had the opportunity to ask questions to Dr. Wil R. McCauley, and my questions have been fully answered. Based on this information:

___ I consent to this treatment. ___ I do not consent to this treatment.

This consent covers the entire course of treatment for my present condition.

Name(print)

Signature

date