The Wootton Clinic and Medical Center, PC
7730 Wolf River Blvd, Suite 112
Germantown, TN 38138
901.756.2424 / fax 756.7504

Account # _________ Date: ________________________

Last Name ______________________________ First Name __________________________________ Birthdate ____________________

SS#_________________________ Age__________ Sex: Male Female Patient Primary Language ________________________

Address ____ City ______________________ State _____ Zip __________

Home Phone ________________________ Work Phone __________________________ Cell Phone ______________________________

Preferred Communication: Home Phone Work Phone Cell Phone Email ____

Occupation _________________________________ Employer ______________________________ Work Phone __________________

Marital Status: Single Married Separated Divorced Widowed Spouse Name ______________________________________

Primary Insurance Company _______________________________________ Subscriber ID# ____________________________________

Secondary Insurance Company ______________________________.________ Subscriber ID# ____________________________________

In case of emergency, Contact ____________________________ Phone ________________________ Relation ____________________

Primary Care Physician ____ Phone __________________________________

How did you hear about us? TV Newspaper Patient Referral __________________ Other ________________________

Race: American Indian or Alaskan Native Native Hawaiian or other Pacific Island Black or African American

Asian White Other: ____________________

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Do you smoke: Never Former Current ó How much _______________________________________

ACCOUNT INFORMATION:

Name ________________________ Relation ________________ SS# ____________________ Driverøs License # __________________

Payment Method: Cash Check Credit Card

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Please Initial

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

I fully understand I am solely responsible for any balance not paid by my insurance.

Please check all of the following that apply to you:

Alcohol/Drug Dependence	Parkinsonøs Disease	Abnormal Weight Gain Loss	HIV+/AIDS/ARC
Prostate Problems	Urinary Problems	Numbness in Groin/Buttocks	Tuberculosis
Steroid Use	Multiple Sclerosis	Arthritis	Lupus
Diabetes	High Blood Pressure	Heart Attack/Stroke (Date) ___________	Mitral Valve Prolapse
GERD	Epilepsy/Seizures	Artificial Bones/Joints/Implants	Osteoporosis
Shingles	Ulcers/Colitis	Heart Surgery/Pacemaker	Glaucoma
Psychiatric Problems	Cancer/Tumor	Chemotherapy/Radiation	Rheumatic Fever
Heart Murmur	Emphysema/Asthma	Congenital Heart Defect	Hepatitis
Atrial Fibrillation	Other Health Problems_______________________________________		

Family History: Cancer Diabetes High Blood Pressure Heart Problems/Stroke Rheumatoid Arthritis

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understand between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. ***Do you have a living will? YES NO***

Patient Signature ____ Date ______________________

PATIENT COMFORT ASSESSMENT GUIDE

Last Name ___________________________ **First Name** _______________________________ **Birthdate** _________________

Describe your current problem and how it began.

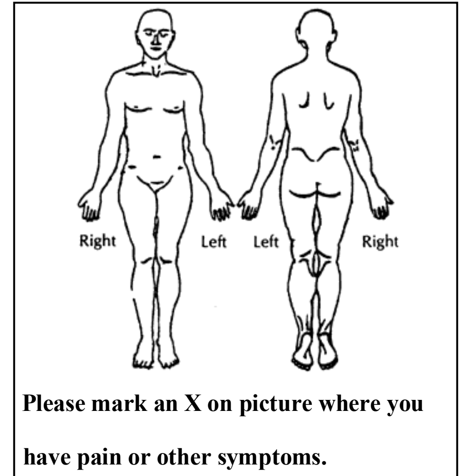
Headache   Neck Pain   Mid-Back Pain   Low Back Pain   Other ______________________________________

Is this?   Work Related   Auto Related   N/A

Date Problem Began _____________________________ How Problem Began ____

Circle the words that describe your pain.

Aching	Sharp	Penetrating	Gnawing
Throbbing	Tender	Nagging	Tiring
Shooting	Burning	Numb	Unbearable
Stabbing	Exhausting	Miserable	



Please mark an X on picture where you have pain or other symptoms.

What time of day is your pain the worst? Circle one.

Morning   Afternoon   Evening   Nighttime

Rate your pain by circling the number that best describes your pain RIGHT NOW.

No Pain   0   1   2   3   4   5   6   7   8   9   10   Pain as bad as you can imagine

What makes your pain BETTER? ____

What makes your pain WORSE? ____

How often are your symptoms present?
(Occasional)   0-25%   26-50%   51-75%   76-100% (Constant)

Have you had spinal x-rays, MRI, or CT scan for your area(s) of complaint?   □ **No**   □ **Yes**
Date(s) Taken __________________________________ **what areas were taken?** ____________________________________

Please list ALL MEDICATIONS you are taking: ____

____

For Women: Birth Control Pills   Currently Pregnant, #Weeks ________   Menstrual Problems

Please list any surgeries you have had: ____

____

Please list any known allergies: ____

____

Have you been treated by a Medical Physician for this condition?   YES   NO   **if so, where?** _________________

____

Have you been treated by a Chiropractor for this condition?   YES   NO   **if so, when was last visit?**

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