CHIROPRACTIC PATIENT UPDATE

Name:____ Phone: ____________________

Do you have a change of address? Yes/No Do you have a change of insurance? Yes/No

Purpose of this appointment: ____

Is this the same problem you were originally under care for? Yes/No

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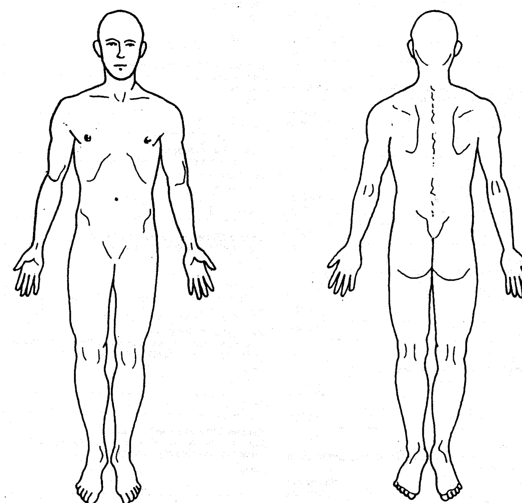
Has it become worse recently? Yes/No Same/Better/Gradually Worse

If yes, when and how? ____

How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___

How long does it last? All Day __________ Few Hours

____________ Minutes ________________



Are there other unrelated health problems? Yes/No. If yes,

describe _______________________________

Describe the pain: Sharp _____ Dull_____ Numbness

_____ Tingling _____ Aching _____ Burning _____

Stabbing _____ Other ____________________________

Is there anything you can do to relieve the problem? Yes/No

If yes, describe _____________. If no, what have you tried to do

that has not helped? _________________________________

What makes the problem worse? Standing ____ Sitting ______ Lying ______ Bending ______

Lifting _____ Twisting _____ Other ____

Have you had any falls or accidents in the past month? Yes/No. If yes, please explain: __________________

____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? Yes/No/Uncertain

Remarks: ____

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NO SYMPTOMS |____| EXTREME SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

Patient Signature: ____ Date: ________________________