CHIROPRACTIC PATIENT UPDATE

You are filling out this form if you have not been seen in our office for 6 months or longer, or if you are experiencing a new medical complaint.
In order to improve our understanding of your current health problems and to provide you with the most accurate treatment plan, please update the following information with regards to any changes in your current health circumstances, contacts, or insurance information. Thank You!

DATE: _____

NAME: _____

AGE: _____ DOB:_____

ADDRESS: _____

CITY: _____STATE:_____ZIP_____

PHONE: HOME: ( ) _____ BUSINESS: ( ) _____CELL:( )_____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT_____ RELATION: _____PHONE:_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance company and this office. I authorize this clinic to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company. **If my condition is a regular health insurance case, I agree to pay a percentage of services as they are rendered and any deductible or co-pays that is required.** However, I understand that I am responsible for payment in full at this office. In case my account goes to collection an automatic $36.00 processing fee will be added to my balance. **I also agree not to raise the Statue of Limitation as a defense.** In addition, if my balance due is over 90 days a rate of 1.5% per month will be added to by balance. I also understand that I will be responsible for the attorney's fees in the amount of 15% of the balance due.

HEALTH INSURANCE: □YES □NO COMPANY_____

YOUR SIGNATURE_____DATE_____

PURPOSE OF THIS APPOINTMENT

WHAT IS YOUR MAIN PROBLEM OR CONDITION: _____

Is this the same problem you first came to this office for? □ Yes □ No

If yes, are there any changes or additional symptoms? _____

Did you have an accident? □Yes □ No If yes: □Auto accident □Work related □ Other_____

Have you lost days from work? □Yes □No If yes, how many_____
When did the problem (or this episode) start? _____
How did it start? _____
Where do you hurt? _____

Is the pain or discomfort: □sharp □ dull □ achy □ burning □shooting □throbbing □stabbing
□ Other: _____

Is the intensity: □ mild □ moderate □ strong □ severe
Is the pain or discomfort: □ constant □ occasional/intermittent
□ other:_____
How frequently does it occur? _____

How long does it last? _____

Is your condition: □ getting better □ about the same □ getting worse

What makes it better? _____

What makes it worse? _____

Have you seen other doctor(s)? Who and when? _____

What treatments have you had? Has it helped? _____

What medications are you taking? _____

Since you were last in this office, have you had any of these? Explain.
- **□ Illnesses: _____**
- **□ Broken bones: _____**
- **□ Accidents or injuries: _____**
- **□ Surgeries or hospital stays: _____**

Since you were last in this office, have you had any changes in your health habits? Explain.
- **□Eating habits, vitamins: _____**
- **□Rapid or unexplained weight gain or loss: _____**
- **□Water, caffeine, alcohol intake: _____**
- **□ Exercise patterns: _____**
- **□Smoking:_____**
- **□ Sleep: _____**

WOMEN ONLY: Are you pregnant? _____
Date of last menstrual period: _____ Last Pap smear: _____
MEN ONLY: Date of last PSA (prostate specific antigen):_____