

Acct # \_\_\_\_\_

**ESTABLISHED PATIENT INFORMATION UPDATE**

IF YOU HAVE RECEIVED THIS FORM, WE HAVE NOT SEEN YOU HERE FOR AFEW MONTHS OR MORE. WE WOULD LIKE TO MAKE SURE WE HAVE YOUR CURRENT PERSONAL INFORMATION CORRECT IN OUR RECORDS AND THE DOCTOR WILL BE UPDATED ON YOUR CURRENT CONDITION. THANK YOU FOR YOUR COOPERATION AND UNDERSTANDING IN THIS MATTER.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

CELL OR PAGER: \_\_\_\_\_ (optional)

EMAIL: \_\_\_\_\_ (optional)

CURRENT INSURANCE NAME: \_\_\_\_\_

CURRENT EMPLOYER: \_\_\_\_\_

**HAVE YOU RECEIVED A NEW INSURANCE CARD SINCE YOUR LAST APPOINTMENT IN OUR OFFICE?**

PLEASE GIVE US THE CARD AND WE WILL COPY IT FOR YOUR CHART AND DO AN INSURANCE VERIFICATION ON YOUR BEHALF SO YOU WILL KNOW YOUR CHIROPRACTIC BENEFITS.

**PLEASE COMPLETE THE INFORMATION SHEET ATTACHED FOR THE DOCTOR. THANK YOU.**

**1. Describe your symptoms**

\_\_\_\_\_

\_\_\_\_\_

a. When did your symptoms start?

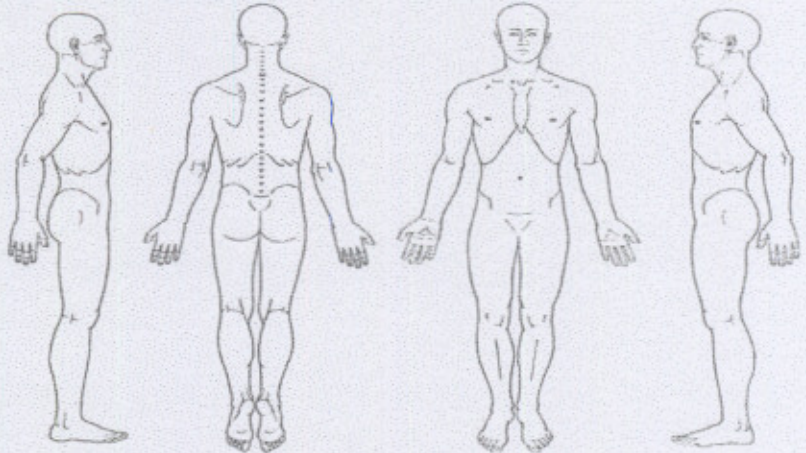
\_\_\_\_\_

b. How did your symptoms begin?

\_\_\_\_\_

**2. How often do you experience your symptoms? Indicate where you have pain or other symptoms**

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



**3. What describes the nature of your symptoms?**

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

**4. How are your symptoms changing?**

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

**5. During the past 4 weeks:**

a. Indicate the average intensity of your symptoms

- None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all
- ② A little bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

**6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)**

- ① All of the time
- ② Most of the time
- ③ Some of the time
- ④ A little of the time
- ⑤ None of the time

**7. In general would you say your overall health right now is...**

- ① Excellent
- ② Very Good
- ③ Good
- ④ Fair
- ⑤ Poor

**8. Who have you seen for your symptoms?**

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when?

\_\_\_\_\_

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: \_\_\_\_\_
- ② MRI date: \_\_\_\_\_
- ③ CT Scan date: \_\_\_\_\_
- ④ Other date: \_\_\_\_\_

**9. Have you had similar symptoms in the past?**

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

**10. What is your occupation?**

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other