

**PATIENT INFORMATION UPDATE**

IN ORDER TO BRING YOUR ORIGINAL CASE HISTORY UP TO DATE, WE MUST HAVE CURRENT INFORMATION REGARDING YOUR PRESENT HEALTH. PLEASE COMPLETE THE FOLLOWING:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent/Guardian Name (If Patient is a minor): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

E-mail \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_  
(Name, phone and relationship to you)

Purpose of this appointment: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Is it getting better, worse or the same? (please circle)

Do you experience: aching, numbness, pain, spasm, stiffness, tingling, weakness, other \_\_\_\_\_? (circle ALL that apply)

% of time you experience symptoms: \_\_\_\_\_ Rate your pain: mild 1 2 3 4 moderate 5 6 7 8 severe 9 10 10+ (circle)

Do your symptoms radiate / refer to any other part of your body? \_\_\_\_\_

Does this condition interfere with your: daily routine / sleep / work / exercise / sports / child-elder care / other? (circle ALL that apply)

What helps your condition? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Have you seen any other chiropractor / medical doctor / other health care practitioner since your last visit? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, whom did you see? \_\_\_\_\_ Are you still under care? \_\_\_\_\_ Date of last treatment? \_\_\_\_\_

Have you had acupuncture, massage or other forms of bodywork? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ What form of exercise? \_\_\_\_\_

What do you do for stress reduction? \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

List ALL medications, vitamins, herbs or homeopathics you are taking: \_\_\_\_\_

List ANY hospitalizations, surgical procedures falls, accidents, and injuries since your last visit: \_\_\_\_\_

Have you been diagnosed or treated for any other medical conditions since your last visit here? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**CONSENT FOR PROFESSIONAL SERVICES**

I hereby authorize the doctor and whomever she may designate as an associate to administer chiropractic examination, chiropractic care, treatment, order x-rays or imaging studies or any other services that she deems necessary in my (or my child's) case.

Patient (Parent/Guardian) signature: \_\_\_\_\_ Date: \_\_\_\_\_