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Chiropractic Update

Last Visit: __/____/___ Patient #: ________________

Last X-ray: ____/____/____❑ 2C ❑ 2L ❑ 2T & ___/____/____ ❑ 2C ❑ 2L ❑ 2T

Name: ____ **DOB:** __________________

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Email: ______________________________ (C) Phone: _________________

Would you like text reminders of your appointments? ❑Y ❑N If yes, cell phone provider _______________

Address: ____

Purpose of this appointment: ____

Is this the same problem you were originally under care for? ❑Y ❑N

If yes, are there any additional symptoms? ____

Have you seen other doctors for this condition? ❑Y ❑N

What medications are you taking? ____

____

Occupation: ______________________________ Employer: ____________________________________

Employers Address: ____ (W) Phone: ___________________

Spouse: ____ Spouse Employer: _________________________

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use the patient's health information for the purpose of treatment, payment, healthcare, operations and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPAA notice that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Date Signed: ______________ **Signature:** ____

Health Care Coverage ❑ Y ❑ N If yes, what? ____

Patient Name: ____ DOB____

1. What is your major symptom? ____
   If this is a recurrence, when was the first time you noticed this problem? ______________________
   How did it originally occur? ____
   Has it become worse recently ❑Y ❑N ❑Same ❑Better ❑Gradually Worse
   If yes, when and how? ____

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

2. How frequent is the condition? ❑Constant ❑Daily ❑Intermittent ❑Night Only

3. How long does it last? ❑All Day ❑Few Hours ❑Minutes

4. Are there any other conditions or symptoms that may be related to your major symptom? ❑Y ❑N
   a. If yes please describe: ____

5. Are there other unrelated health issues? ❑Y ❑N If yes, describe __________________________
   ____

6. Describe the symptoms: ❑Sharp ❑Dull ❑Numbness ❑Tingling ❑Aching ❑Burning ❑Stabbing

7. Is there anything you can do to relieve the problem? ❑Y ❑N
   a. If yes describe: ____
   b. If no, what have you tried that doesn't help? _______________________________

8. What makes the problem worse? ❑Standing ❑Sitting ❑Lying ❑Bending ❑Lifting ❑Twisting
   other: ____

9. List any major accidents you have had other than those that might be mentioned above: ____________
   ____

10. To your knowledge, have you had any diseases, major illness, or injuries not indicated on this form either in the past or the present? ❑Y ❑N If yes, please explain: ______________________
   ____

11. What reason did you stop your wellness care/treatment plan prior:
   ❑Insurance ❑Financial ❑Schedule conflict ❑ Felt better ❑Other: ____________________

12. **Women Only:** Are you pregnant or is there any possibility you may be pregnant?
   ❑Y ❑N ❑Uncertain

13. Anything else you would like to discuss with the doctor? ______________________________
   ____
   ____
   ____

Doctors Signature: ____ Date: __________________