

# CHIROPRACTIC PATIENT UPDATE

Please complete Parts A & C in all cases. Part B should be completed only if the information has changed since you were last in our office.

*Thank You*

Birthdate \_\_\_\_\_ S.S. # \_\_\_\_\_

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## PART A

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_  
Street or Box Number City State Zip

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

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

If yes, are there additional symptoms? \_\_\_\_\_

Other doctors seen for this condition: \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

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## PART B

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's address \_\_\_\_\_ Work phone \_\_\_\_\_

Spouse \_\_\_\_\_ Spouse's employer \_\_\_\_\_

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## PART C

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I request this chiropractic clinic to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. 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.

\_\_\_\_\_  
Signature

Health Insurance Coverage? ( ) Yes ( ) No

Company \_\_\_\_\_

CHIROPRACTIC PATIENT UPDATE

1. What symptoms are you now experiencing? \_\_\_\_\_  
\_\_\_\_\_
2. When did the most recent episode of pain begin? \_\_\_\_\_  
\_\_\_\_\_
3. How did it occur? \_\_\_\_\_  
\_\_\_\_\_
4. Where were you when the symptoms started? \_\_\_\_\_
5. How frequent is the condition? \_\_\_\_\_
6. When do you experience pain? \_\_\_\_\_
7. What type of pain is it, sharp, ache, etc.? \_\_\_\_\_
8. Does anything provide relief? \_\_\_\_\_
9. What makes it worse? \_\_\_\_\_
10. Since the onset of symptoms are you getting better, worse, same? \_\_\_\_\_
11. Who is your family medical doctor/clinic? \_\_\_\_\_  
\_\_\_\_\_
12. Are you currently being treated for any other medical/health problems? \_\_\_\_\_
13. List current medications. \_\_\_\_\_
14. When did you last see your MD? List reason. \_\_\_\_\_
15. List any injuries/broken bones/ surgeries, etc. since last visit.
16. Any other chiropractic treatment since last visit? List name/date. \_\_\_\_\_
17. For women only: Pregnant?    Yes / No / Not Sure            (Circle one)

Date \_\_\_\_\_ Signed \_\_\_\_\_