Family Chiropractic CLINIC

DR. JEFF HAND
DR. JENNIFER PERSON
DR. JOSH HOLBROOK
Doctors of Chiropractic

Patient Update Form

Please allow our staff to photocopy your driver's license and insurance details.
Please note that this is confidential

Today's Date _____

Last Name First Name Middle Name

Address Date of Birth (MM/DD/YY)

City State Zip Code Home Phone Cell Phone

Ethnicity: □ Hispanic □ non-Hispanic □ refuse **Language Spoken**: □ English □ Other_____

Marital Status: □ Single □ Divorced □ Widow □ Separated □ Married

Race: □ White □ African American □Hispanic □ American Indian □ Asian □ More than one race □ refused

Email Address _____ **Spouses Name**_____

Emergency Contact_____ **Phone** _____

Your Occupation_____

Your Employers Name_____ **Work Phone**_____
May we contact you at work? □ Yes □ No

Employer Contact_____

Primary Care Providers Name and Clinic Location_____

Insurance Carrier_____ **Policy number**_____

Insured's First and Last Name _____ **Policy Carrier** □ Self □ Spouse □ Parent

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NAME _____

The symptom(s) that have prompted me to seek care today include:_____

_____

How did your symptoms start? _____

_____

When did you first notice your current symptom? _____

Intensity (how extreme are your current symptoms? (please circle one)

Absent 0 1 2 3 4 5 6 7 8 9 10 Agonizing

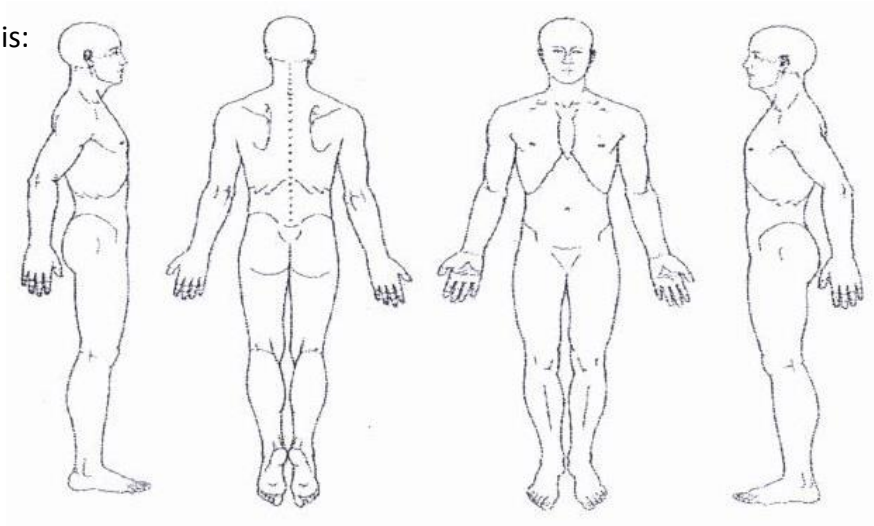
Duration and Timing (When did it start and how often do you feel it?

☐ Constant ☐ Comes and goes How Often? _____

Does the pain radiate shoot or travel and where?_____

Please show where your pain is:

□ Numbness
□ Tingling
□ Stiffness
□ Aching
□ Cramps
□ Nagging
□ Sharp
□ Burning
□ Shooting
□ Throbbing
□ Stabbing
□ Other



What makes the pain worse_____Better? _____

Previous treatments

□ Prescription medications	□ Surgery	□ Ice	□ Other _____
□ Over the counter medicine	□ Acupuncture	□ Heat	
□ Physical Therapy	□ Chiropractic	□ Massage	

What else should the doctor at Family Chiropractic know about your condition? _____

_____

Please list ALL current medications and supplements _____

_____

Are you currently pregnant? □ Yes □ No Due date? _____ Number live births _____

NAME _____

Updated Social history

Alcohol use	□ Daily	□ Weekly	□ How much _____
Coffee use	□ Daily	□ Weekly	□ How many cups daily _____
Tobacco use	□ Daily	□ Weekly	□ How many packs a day_____
Exercise	□ Daily	□ Weekly	□ How many times weekly_____
Pain reliever	□ Daily	□ Weekly	□ How much_____

Activities of Daily Living – How does your condition interfere with life and ability to function?

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Sitting					Grocery Shopping				
Rising out of chair					Household chores				
Standing					Lifting objects				
Walking					Reaching overhead				
Lying down					Showering/bathing				
Bending over					Dressing				
Climbing Stairs					Rolling in bed				
Using a computer					Getting to sleep				
Getting in/out of a car					Staying asleep				
Driving a car					Concentrating				
Looking over shoulder					Exercising				

New surgical procedures or injuries _____

_____

Please list any new or updated imaging since your last visit

□ MRI _____ □ X-rays_____ □ CT Scan_____ □ Other_____

_____

Signature Date (MM/DD/YYYY)