

# 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!*

## PART A

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Fax # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address: \_\_\_\_\_

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

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

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

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

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

## PART B

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

Employer's address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

## PART C

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs 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. I understand that interest is charged on overdue accounts at the annual rate of (16%).

The patient understands and agrees to allow this chiropractic office to use their Patient 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 Insurance Coverage ☐ Yes ☐ No

Company: \_\_\_\_\_

Name \_\_\_\_\_

1. What is your major symptom? \_\_\_\_\_
2. If this is a recurrence, when was the first time you noticed this problem? \_\_\_\_\_  
How did it originally occur? \_\_\_\_\_  
Has it become worse recently? Yes \_\_\_ No \_\_\_ Same \_\_\_ Better \_\_\_ Gradually Worse \_\_\_  
If yes, when and how? \_\_\_\_\_
3. How frequent is the condition? Constant \_\_\_ Daily \_\_\_ Intermittent \_\_\_ Night Only \_\_\_  
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?  
Yes \_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_  
Are there other unrelated health problems? Yes \_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_
5. Describe the pain: Sharp \_\_\_ Dull \_\_\_ Numbness \_\_\_ Tingling \_\_\_ Aching \_\_\_  
Burning \_\_\_ Stabbing \_\_\_ Other \_\_\_\_\_
6. Is there anything you can do to relieve the problem? Yes \_\_\_ No \_\_\_\_\_. If yes, describe \_\_\_\_\_  
\_\_\_\_\_. If no, what have you tried to do that has not helped? \_\_\_\_\_  
\_\_\_\_\_
7. What makes the problem worse? Standing \_\_\_ Sitting \_\_\_ Lying \_\_\_ Bending \_\_\_  
Lifting \_\_\_ Twisting \_\_\_ Other \_\_\_\_\_
8. Have you had any broken bones? Yes \_\_\_ No \_\_\_\_\_. If yes, please list and give dates \_\_\_\_\_  
\_\_\_\_\_
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 illnesses, or injuries not indicated on this form either in the past or the present? Yes \_\_\_ No \_\_\_\_\_. If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
11. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  
Yes \_\_\_ No \_\_\_ Uncertain \_\_\_\_\_
12. Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NO  
SYMPTOMS

EXTREME  
SYMPTOMS

Please place an "X" on the line above to indicate your level of problem.

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_



**Office Use Only**

☐ 1

☐ 4-5

☐ >5

## Pain Drawing

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### TELL US WHERE YOU HURT.

***Please read carefully:***

*Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.*

Ache >>>>>

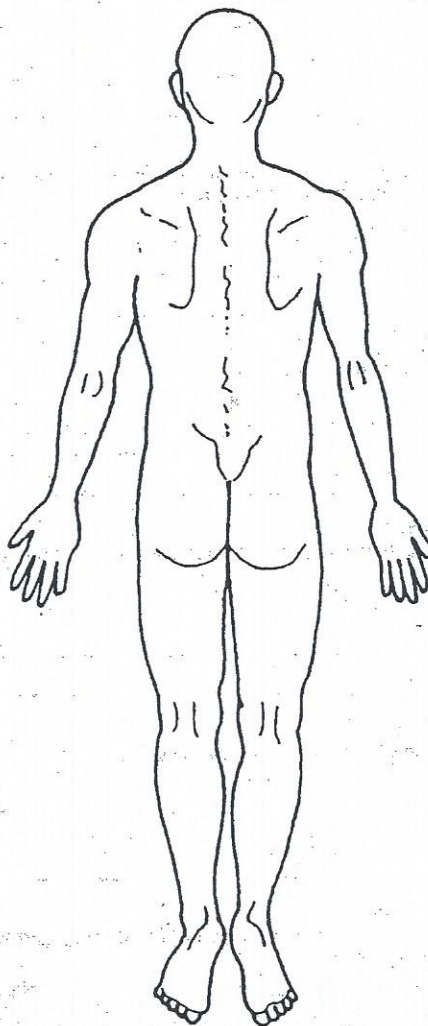
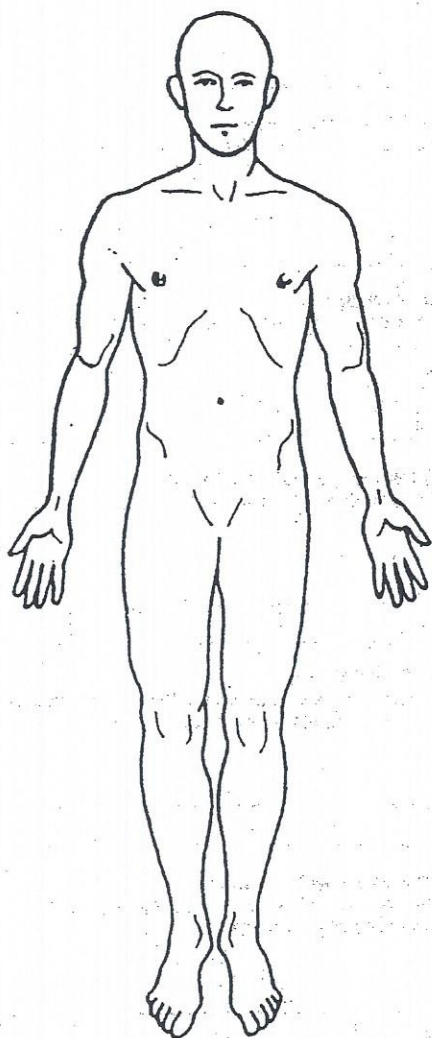
Burning x x x x

Numbness =====

Stabbing /////

Pins & Needles o o o o

Throbbing ~~~~~



Name \_\_\_\_\_

Date \_\_\_\_\_

### Quadruple Visual Analogue Scale

Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain and at its best and worst.

**Please circle the areas of complaint you are having below.**

Headaches

Neck Pain

Mid-back Pain

Low-back Pain

Hips/Leg Pain

**What is your pain RIGHT NOW?**

No Pain-----Worst Possible Pain  
0      1      2      3      4      5      6      7      8      9      10

**What is your TYPICAL or AVERAGE pain?**

No Pain-----Worst Possible Pain  
0      1      2      3      4      5      6      7      8      9      10

**What is your pain level AT ITS BEST (how close to "0" does your pain get at its best)?**

No Pain-----Worst Possible Pain  
0      1      2      3      4      5      6      7      8      9      10

**What is your pain level AT ITS WORST (how close to "10" does your pain get at its worst)?**

No Pain-----Worst Possible Pain  
0      1      2      3      4      5      6      7      8      9      10

Other Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date