NAME/ADDRESS OF CLINIC/PROVIDER

PATIENT UPDATE FORM

PART A

Name: ______________________________ DOB ______________

E-mail address: ______________ Cell Phone ______________ Home Phone ______________

Address: ______________________________

Purpose of this appointment: ______________________________

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

If no, what is your current health issue? ______________________________

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: ______________________

Insurance Carrier ______________________ Policy # ______________________

Insurance Carrier Phone # ______________________________

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 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 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: ______________________________

Reviewed by ______________________________

Signature of Reviewer ______________________________

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NAME/ADDRESS OF CLINIC/PROVIDER
PATIENT UPDATE FORM

NAME OF PATIENT_______________________________________ DOB________________________

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.

Patient Signature ____ Date _____________

Doctor's Signature ____ Date _____________

Reviewed by ______________________________________

Signature of Reviewer _______________________________

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