Chiropractic Patient Update

You are filling out this form *if you have not been seen in our office for 6 months or longer, if you are experiencing a new medical complaint, or if you need to make any updates on your existing condition*. In order to improve our understanding of your current health problems and to provide you with the most accurate treatment plan, please update the following information with regards to any changes in your current health circumstances, contacts, or insurance information. In order for us to understand your health problems, please complete the form below. After review and examination, if we do not sincerely believe your problem will respond favorable to chiropractic care, we will not accept your case. We will refer you to a specialist we believe will help you. Thank you for selecting Chiropractic Professional Center as part of your health care team.

Date:_____

Name:_____

Age:_____ DOB:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone #: (Home) _____(Cell) _____ (Work)_____

Occupation: _____ Employer: _____

Emergency Contact _____ Relationship _____ Phone # _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance company and this office. I authorize this clinic to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company**. If my condition is a regular health insurance case, I agree to pay a percentage of services as they are rendered and any deductible or co-pays that is required.** However, I understand that I am responsible for payment in full at this office. In case my account goes to collection an automatic $36.00 processing fee will be added to my balance. **I also agree not to raise the Statue of Limitations as a defense.** In addition, if my balance due is over 90 days a rate of 1.5% per month will be added to my balance. I also understand that I will be responsible for the attorney's fee in the amount of 15% of the balance due.

Health Insurance: YES NO COMPANY:_____

Your Signature:_____ Date:_____

OVER→

Purpose of this Appointment

WHAT IS YOUR MAIN PROBLEM OR CONDITION: _____

Is this the same problem you first came in to this office for? YES NO

If yes, are there any changes or additional symptoms? _____

Did you have an accident? YES NO If yes: Auto Accident Work Related Other_____

Have you lost days from work? YES NO If yes, how many _____
When did the problem (or this episode) start? _____
How did it start? _____
Where do you hurt? _____

Is the pain or discomfort: SHARP DULL ACHY BURNING SHOOTING THROBBING STABBING
OTHER: _____
Is the intensity: MILD MODERATE STRONG SEVERE
Is the pain or discomfort: CONSTANT OCCASIONAL/INTERMITTENT OTHER: _____

How frequently does it occur? _____

How long does it last? _____

Is your condition: GETTING BETTER ABOUT THE SAME GETTING WORSE
What makes it better? _____
What makes it worse? _____
Have you seen other doctor(s)? Who and when? _____
What treatments have you had? Had it helped? _____
What medications are you taking? _____
_____

Since you were last in this office, have you had any of these? Explain.
Illnesses: _____
Broken bones: _____
Accidents or injuries: _____
Surgeries or hospital stays: _____

Since you were last in this office, have you had any changes in your health habits? Explain.
Eating habits, vitamins: _____
Rapid or unexplained weight gain or loss: _____
Water, caffeine, alcohol intake: _____
Exercise patterns: _____
Smoking: _____
Sleep: _____

Women ONLY: Are you pregnant? YES NO Date of last menstrual period:_____ Last pap smear:_____
Men ONLY: Date of last PSA (prostate specific antigen):_____

Dr. Initial:_____