Patient Information Update

Date____/____/____
Patient number_____

Name_____ Date of Birth _____
Address_____
City _____State _____Zip Code _____
Home Phone_____ Work phone _____
Cell Phone _____ Email Address_____
Would you like to receive text or email appointment reminders? Y/N Cell carrier _____

Please list your major complaints in order of severity: (Note Secondary If Applicable)
Primary: _____
Secondary:_____

PRIMARY COMPLAINT:
When did this condition develop?_____ Did it develop? (Circle one) Immediately/Gradually?
What is the exact location of your symptoms?_____
What do you think caused this condition?_____

How often do you experience these symptoms? (Circle one)
Constant / Frequent (75%) / Often (50%) / Seldom (25%) / Rarely (less than 25%)

What is the type of pain you are experiencing? (Circle all that apply)
Dull Sharp Burning Aching Stabbing Throbbing Numbness Twitching

Rate your symptoms on a scale of 1-10 (circle one) minimal 1 2 3 4 5 6 7 8 9 10 severe

Does the pain travel or radiate to another area of your body? YES___ NO___
If yes, what area? _____

What provokes or aggravates your condition (circle all that apply)?
Sitting / Standing / Walking / Lying/ Pushing / Pulling / Lifting / Hot / Cold / Sneezing / Bowel Movements

What helps alleviate pain (circle all that apply)?
Sitting / Standing / Walking / Lying / Rest / Hot / Cold

Please list any doctors that you have seen for this condition (Include address, phone numbers, fax numbers, diagnosis, treatment received, and any change in your condition since you have received Treatment):_____
_____
List any falls, surgeries, hospitalizations, or accidents since your last visit: _____

Family Doctor _____ May we contact them? Yes/No

Patient Name _____

The following questions are required as a result of the Affordable Healthcare Act. Thank you for your cooperation.

Race (Please circle only one):

American Indian or Alaska Native
African American/Black
Asian
Caucasian/ White
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
Not Provided

Ethnicity: (Please circle only one)

Hispanic or Latino Not Hispanic or Latino Not Provided

Preferred Language: _____

LIST ANY AND ALL ALLERGIES TO MEDICATIONS

1. _____
2. _____
3. _____
4. _____

LIST ALL MEDICATIONS TAKEN AND FOR WHAT CONDITIONS:

Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____

CONSENT TO ACCESS MEDICATION HISTORY:

I authorize First Choice Chiropractic to retrieve my medication history from the SureScripts website, Dr First:
Patient Signature: _____

LIST ALL VITAMINS AND MINERALS TAKEN AND FOR WHAT CONDITIONS:

Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____
Name: _____ Dosage: _____ Frequency: _____ For What: _____

SMOKER STATUS(For all Patients over age 13):

Are you a smoker? YES/NO If yes, how many cigarettes per day? _____
Were you a smoker? YES/NO If yes, when did you quit?
Are you a "Never smoker"? (Less than 100 cigarettes in a lifetime) YES/NO

EXERCISE: Do you exercise at a moderate intensity a minimum of 3 x per weeks? Yes or No (circle one)

Current Height: _____
Current Weight: _____