PATIENT HISTORY UPDATE **RN:**

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W # of Children ____

Employer: _____ Home Phone: _____

Employer's Address: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

PLEASE SUPPLY INFORMATION FOR BOTH INSURANCE CARRIERS (IF APPLICABLE)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Patient relationship to insured	☐ Self ☐ Child ☐ Spouse ☐ Other	☐ Self ☐ Child ☐ Spouse ☐ Other
Insurance Carrier Name:		
Insured's Name:		
Insured's Date of Birth		
Insured's ID#:		

Date of onset of these symptoms: _____

How did symptoms begin? _____

Are your symptoms due to: ☐ Auto Accident ☐ Work ☐ Sports ☐ Other _____

Have you ever had similar symptoms or injuries before? ☐ Yes ☐ No If Yes, When? _____

Other Doctors seen for these symptoms and when: _____

In what way does this interfere with your normal activities and/or work? _____

Have you lost time from work? ☐ Yes ☐ No Dates: _____ to _____

When are you most uncomfortable? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Other _____

What activities or positions make your symptoms worse?

☐ Sitting ☐ Standing ☐ Lying Down ☐ Bending ☐ Lifting ☐ Walking ☐ Other_____

What makes your symptoms feel better? _____

What is the **quality** of your pain? ☐ Dull ☐ Sharp ☐ Throbbing ☐ Ache ☐ Burning ☐ Numbness ☐ Tingling

Frequency of your symptoms:

☐ Occasionally 0 – 25% of the time ☐ Intermittently 26-50% of the time ☐ Frequently 51-75% of the time ☐ Constantly 76-100% of the time

Recent falls or accidents: _____

Recent health problems or surgery: _____

Approximate date of last chiropractic treatment: _____ Doctor: _____

FAMILY HEALTH HISTORY

	Heart Disease	Stroke	Arthritis	Diabetes	Cancer	Other
Father						
Mother						
Grandparents						
Brother/Sister						

_____ _____

Patient / Guardian signature Date