Swickard Chiropractic Clinic Chtd.
Dr. Bruce Swickard
Dr. Nicholas Swickard
15050 Antioch Road Ste 102
Overland Park, KS 66221
913-897-6717

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Your Last Name

Gender
○ Male ○ Female

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Age

Marital Status
○ Single ○ Married ○ Divorced
○ Widowed ○ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Address

Preferred method of contact?
○ Home Phone ○ Cell Phone
○ Work Phone ○ Email

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name

Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

I certify that any changes to my personal information have been updated above for your records.

Signature

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UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY)

Your Last Name | Your First Name | Your Middle Name (or Initial)

○ I have new contact information

Please select one:

○ **Progress evaluation** – I've been under active care and this is a periodic reevaluation.
○ **New condition** – I've been under care and a new or returning condition has emerged.
○ **Maintenance patient** – I'm under maintenance care with a new or returning health issue.
○ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

This updated patient history is for:

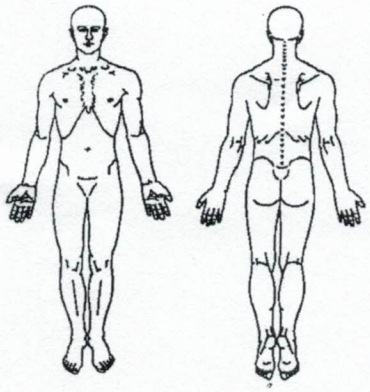
○ Current Patient
Periodic Re-evaluation

○ Current Patient
Additional Complaint/
Exacerbation

○ Maintenance Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

○ Inactive Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

1. Location (Where does it hurt?)
Circle the area (s) on the illustration.



2. Quality of symptoms (What does it feel like?)

○ Numbness
○ Tingling
○ Stiffness
○ Dull
○ Aching
○ Cramps
○ Nagging
○ Sharp
○ Burning
○ Shooting
○ Throbbing
○ Stabbing
○ Other

3. Intensity (How extreme are your current symptoms?)

0 ○—○—○—○—○—○—○—○—○—○ 10
Absent Uncomfortable Agonizing

4. Duration and Timing (When did it start and how often do you feel it?)

○ Constant ○ Come and goes.

When did it start and how often? _____

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

7. Prior interventions (What have you done to relieve the symptoms?)

○ Prescription medication ○ Surgery ○ Ice
○ Over-the-counter drugs ○ Acupuncture ○ Heat
○ Homeopathic remedies ○ Chiropractic Other _____
○ Physical therapy ○ Massage _____

8. What else should Dr. Swickard know about your current condition?

_____
_____
_____

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	○	○	○
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	○	○	○
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	○	○	○
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	○	○	○
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	○	○	○
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	○	○	○
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	○	○	○
h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	○	○	○
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	○	○	○
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	○	○	○

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

_____
_____

Consultation Notes

UPDATED PATIENT HISTORY

Doctor's Initials

11. Social History (Tell the Dr. Swickard about your health habits and stress levels.)

Alcohol use	○ Daily	○ Weekly	How much? _____
Coffee use	○ Daily	○ Weekly	How much? _____
Tobacco use	○ Daily	○ Weekly	How much? _____
Exercising	○ Daily	○ Weekly	How much? _____
Pain relievers	○ Daily	○ Weekly	How much? _____
Soft drinks	○ Daily	○ Weekly	How much? _____
Water intake	○ Daily	○ Weekly	How much? _____

Hobbies: _____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

12. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. Is there anything else Dr. Swickard should know about your current condition, your progress or ways your current condition is affecting your life?

_____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Signature

Date (MM/DD/YYYY)

Consultation Notes

Patient name

Doctor's Initials

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