CHIRO-HEALTH
CHIROPRACTIC CARE CENTER

PATIENT UPDATE FORM

Name: _____ Date of Birth: _____ Date: _____

Email Address: _____

Phone Number: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone Number: _____

1. Describe the problems you are presently having (Be as specific as possible)

   _____

2. Mark where you feel the following sensations.
   Use the appropriate symbols.

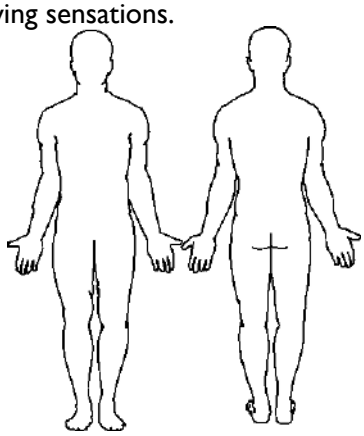
   Numbness - - - - - -

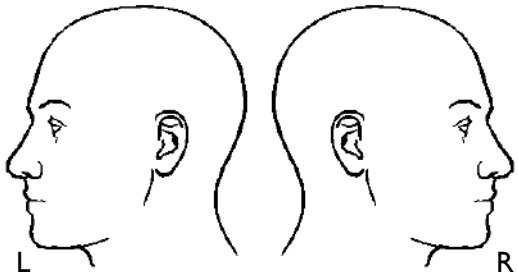
   Pins & Needles ++++++

   Burning XXXXX

   Dull Ache oooooo

   Stabbing Pain / / / / / / /





3. How has your condition changed since your last examination?

   _____

4. PAIN LEVEL: On a scale of 0-10, with 0 being you're pain-free and can function quite well, and 10 being you're in severe pain and cannot function at all, place an X on the line where you would rate yourself.

   0 10

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   NO PAIN VERY SEVERE PAIN

5. Describe and date any accidents, injuries, or disease you have had since your last exam:

   _____

6. What positions, movements or activities make the problem WORSE?

   _____

7. What positions, movements or activities make the problem BETTER?

   _____

8. Please list any other health care issues you have:

   _____

Patient Signature: _____