CONFIDENTIAL PATIENT UPDATE FORM

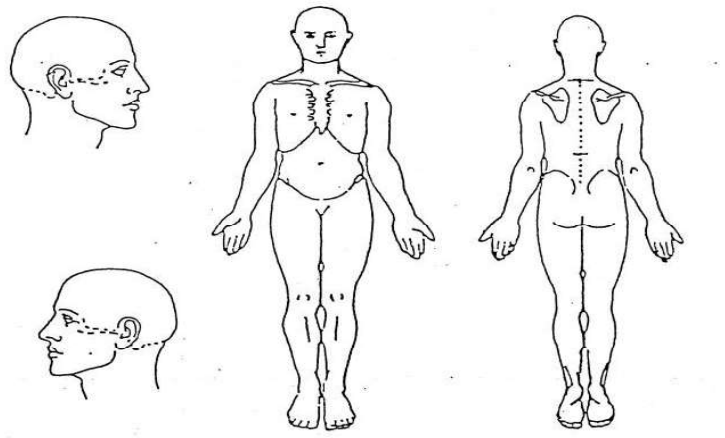
Name: _____ Age: _____ Date: _____/_____/_____

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	XXXXXXXXXXXXXXXXX
Dull Ache	0 0 0 0 0 0 0 0 0 0 0 0 0 0
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, where would you rate yourself? (Place an X on the line)

   0 /----------/10

   NO PAIN SEVERE PAIN

5. Describe and date **any** accidents, injuries or diseases 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. Do you have any new health problems or symptoms that you haven't told us about? **Y** **N**

   If "yes", please describe:

   _____

   _____

Patient Signature: _____ CA **initials:** _____

IF YOUR INFORMATION HAS CHANGED:

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Email: _____ @ _____. com

Employer: _____ Occupation:_____

Emergency Contact: _____Phone: _____

I understand that payment is required at time of service. Most medical insurance and most credit cards are accepted. I understand and agree that health accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I further agree to pay all collection agency fees, attorney fees, court fees, and other related costs incurred in the collection of my account.

I authorize the release of my medical records to the physician or physicians to whom I may be referred. I authorize the release of any medical information necessary to process insurance claims.

Patient Signature: _____Date: _____

McAvoy Chiropractic

BALANCED HEALTHCARE