Date_____ File #_____ DR _____

Northern Life Wellness Patient Update Form

Personal Information

Patient Name:_____ Date of Birth: ____/____/_____

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

Phone Number (h) (_____)_____-_____ (c) (_____)_____-_____ (w) (_____)_____-_____

Email: _____

Occupation: _____ Employer: _____

Status :☐ Married ☐ Single ☐ Other, Emergency Contact: _____ Phone #: _____

Have you been in an automobile accident or injured at work in the last six (6) months? ☐ Yes ☐ No
If yes – please return to the front desk and speak with a Front Desk Coordinator regarding your visit.

Current Health Insurance Information

Insurance Carrier: _____

Policy ID #: _____ Group #: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Present Condition & Medical Status

What is your major complaint? _____

When did it begin? _____ Is it getting ☐ Better ☐ Worse ☐ Staying the Same

Rate your pain intensity on a scale of 0 (no pain) to 10 (most severe): _____

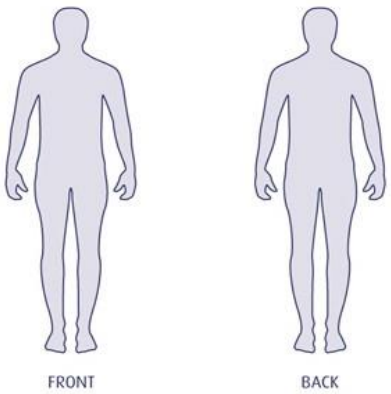
Please rate your overall restriction to activities of daily living on a scale of 0 (no pain) to 10 (most severe): _____

List other complaints followed by when they began their level of pain intensity? _____
_____
_____
_____

I have difficulty with: ☐ Lifting ☐ Walking ☐ Standing ☐ Sitting ☐ Sleeping ☐ Other: _____

Pain Diagram:

Please mark the location of your pain on the figures to the right.



Northern Life Wellness Patient Health History

Primary Care Physician:_____ Clinic Phone #:_____

Name & Location of Clinic:_____

List any Medications/Supplements you are taking: _____

Females: Are you pregnant: □Yes □No

My signature indicates that, "This is to certify, to the best of my knowledge that I am not pregnant at this time. I hereby authorize the Wellness Clinic to take X-Rays as necessary to determine the status of my spine. I will assume all responsibility for any effects on a fetus potentially present"

Printed name:_____

Signature:_____ Date:_____

Check any of the following conditions you have had:

□ Aids/HIV	□ Ear ringing	□ Neck Pain
□ Allergies	□ Epilepsy	□ Osteoporosis
□ Anxiety/Depression	□ Headaches	□ Poor circulation
□ Arm/Shoulder pain	□ Headaches-Migraine	□ Prostate problems
□ Arthritis	□ Heart disease	□ Rheumatoid Arthritis
□ Asthma	□ Hemorrhoids	□ Sciatica
□ Bladder problems	□ Herniated disk	□ Shingles
□ Cancer	□ High blood pressure	□ Sinus infection
□ Chronic fatigue	□ Insomnia	□ Stroke
□ Deafness	□ Irregular cycle	□ Thyroid problems
□ Diabetes	□ Kidney problem	□ TMJ
□ Digestion problems	□ Leg pain	□ Venereal disease
□ Earache	□ Low back pain	□ Vertigo/Dizziness

□ Other _____

Stressors

□ Smoking Packs/day: _____
□ Alcohol Drinks/week: _____
□ Coffee/Caffeine Cups/day: _____
□ High Stress Level Reason: _____
□ Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Have you had any:	**Description**	**Date**
Automobile accidents: □No □Yes	_____	_____
Surgeries: □No □Yes	_____	_____
Broken bones: □No □Yes	_____	_____
Falls/Head injuries: □No □Yes	_____	_____

Significant Family Histoy:_____

X I hereby authorize this office and its doctors to administer care to myself or my child as they deem necessary.

Date:_____Signature_____ Parent (if minor)_____