WELCOME BACK TO NEW YORK CHIROPRACTIC ASSOCIATES

PATIENT UPDATE FORM

Welcome Back! Please take a few moment to help us update your records. Thank You.

PERSONAL INFORMATION

First Name _____ Last Name _____ DOB: _____

Address_____City_____State_____Zip_____

Home Tel. (_____) _____ -_____ Work Tel.(_____) _____-_____ Email _____

PRESENT CONDITION & MEDICAL STATUS

What is your major complaint? _____

When did it begin? _____ Is it getting: better □ worse □ staying the same□

Please rate your pain intensity (0 = no pain, 10 = most severe) _____

Please list any other complaints followed by when they began and their level of pain intensity:

_____

_____

I have difficulty with: □ **L**ifting □ **W**alking □ **S**tanding □ **S**itting □ **D**riving □ Sleeping □ **O**ther_____

Rate your overall restriction to activities of daily living (0=no restriction, 10=completely restricted) ____

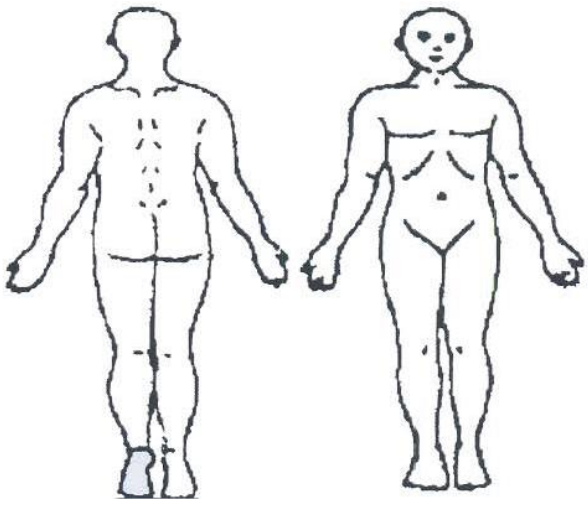
To the best of your knowledge, are you currently pregnant? **YES / NO**

If yes, when was your last menstrual period? _____

Please list any illness, injury, surgery, hospitalization or changes in your medical status since your last visit: _____

_____

PAIN DIAGRAM: Please mark the location of your pain on the figure below



PLEASE SEE BACK →

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CURRENT INSURANCE INFORMATION:

Insurance Carrier: _____Group # _____

Insurance ID #_____

Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's DOB: _____

I understand that all treatments rendered in this office will be charged directly to me unless our office agrees to accept your insurance on assignment. If your claims are denied by your insurance carrier, you will be financially responsible for the visit(s). All deductibles, coinsurance and copayments are due at the time treatment is rendered.

Patient's Signature_____ Date_____

Doctor's Notes:

_____

_____

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