LANGEL CHIRORPACTIC CLINIC, P.C.
PATIENT UPDATE

Name: _____ Date _____ ID No. _____

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

Home Phone: _____-_____-_____Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

☐ Email Appointment Reminders ☐ Text Appointment Reminders: Cell Phone Carrier: _____

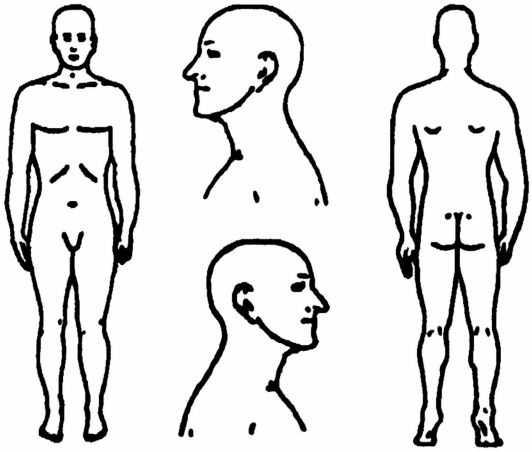
Email Address:_____ Occupation & Employer: _____

Date of Birth: _____ Marital Status: _M _S _W _D Name of Spouse: _____

Primary Insurance _____ Secondary Insurance _____

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Other _____

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Describe MAJOR complaint:

_____

_____

Date problem began: __/__/__ It came on __suddenly __ gradually

How did this problem begin (falling, lifting, etc)? _____

_____

How is your condition changing?
☐ GETTING BETTER ☐ GETTING WORSE ☐ NOT CHANGING

Have you received treatment for this? YES - NO If so by whom? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms:

☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling ☐ Achy ☐ Stiff ☐Sore

☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Other: _____

Please rate your pain (0= no pain and 10= excruciating pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain Intensity: Minimum – Mild – Moderate – Severe – Unbearable

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes your pain better (ice, heat, massage, etc)? _____

What activities aggravate your condition (working, exercise, etc)? _____

If Female, are you pregnant? YES – NO How many weeks? ____

Since your last visit has there been any surgery, trauma, illness, or change in your medications? YES NO

Please describe:

_____

Patient's signature _____ DATE _____