CHIRO-MED, S.C.

accident | work & sports injuries | rehabilitation
| chiropractic | preventive & wellness center |

PATIENT UPDATE FORM

Name: ____ Date: ________________________________

Address: ____

City: ____State: ___________Zip: ______________

Phone number: _______________________ Cell: ______________________ Work: ___________________

Email address: ____

Emergency Contact (relationship & phone number): ____

Do you have a change in insurance? **Yes / No** (If yes, please provide the Front Desk with your insurance card.)

Last visit at Chiro-Med was on: _________________ Date symptoms began: __________________________

Current symptoms:____

____

How these symptoms began: ____

____

How severe is your pain on a scale of 1-10 (0 being no pain and 10 being the worst pain imaginable)? _______

What makes your pain better? ____

What makes your pain worse? ____

Have you ever had pain like this before ? ____

Have you had any illnesses, accidents, or injuries since your last visit? ________________________________

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Is there anything we should know about your condition or you before we begin treatment? ________________

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I understand that if I am accepted as a patient of this clinic, I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic and acupuncture treatment will be explained to me upon request. I, the undersigned, certify that I (or my dependents) have insurance coverage and assign directly to this clinic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

___________________________________ ___________________________________ ___________________

Patient or responsible party signature Relationship to patient Date