WELCOME BACK TO NEW YORK CHIROPRACTIC ASSOCIATES

PATIENT UPDATE FORM

Dear Patient,

Welcome Back! Please take a few moments to help us update your records. Thank you.

PERSONAL INFORMATION

Name ____

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 other complaints followed by when they began and their level of pain intensity: ____________________

____

I have difficulty with: lifting ☐ walking ☐ standing ☐ sitting ☐ sleeping ☐ Other____________

Please 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? _____________________________

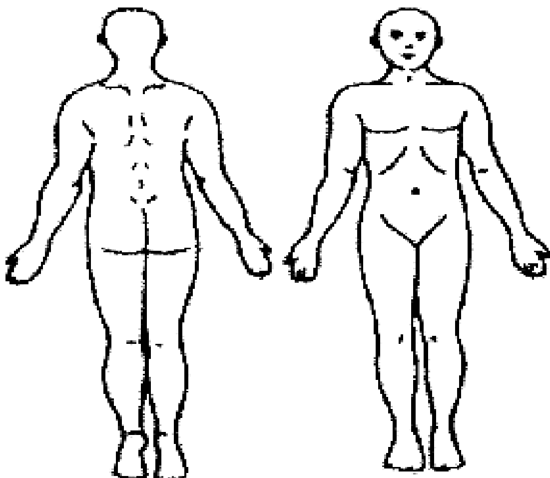
Please list any illness, injury, surgery, hospitalization or changes in your medical status since your last visit:

____

____

PAIN DIAGRAM:

Please mark the location of your pain on the figures below:



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CURRENT INSURANCE INFORMATION:

Insurance Carrier: ______________________________

Insurance ID # ________________________________ **Group #** ______________________

Policyholder ___________________________________ **Relationship to Policyholder**______________________

Policyholder's Date of Birth ______________________

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 visits. All deductibles, coinsurances and co-payments are due at the time treatment is rendered.

Patient's Signature ____ Date _________________________

Doctor's Notes:

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