CASE HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original case history up to date, please provide us with the following information. PLEASE PRINT.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Home Telephone Number: _____ Cell Telephone Number: _____

Date of Birth: _____

1. Is your visit to this clinic in reference to an accident: [ ] Yes [ ] No

   If Yes, was it: [ ] Work Comp [ ] Auto [ ] Personal Injury [ ] Other _____

2. List present complaints (describe fully): _____

   _____

   _____

3. Grade your symptoms (1 minimal – 10 severe): _____ Duration of condition: _____

4. Describe any falls, surgery, and/or accidents since your last visit: _____

   _____

   _____

5. Date of last physical: _____ Date of last adjustment: _____

6. Since your last visit to our office, have you consulted another Doctor? [ ] Yes [ ] No

   If so, please give the Doctor's name: _____

   And condition for which you were treated: _____

7. What type of treatment did you receive? _____

8. What medications or drugs are you taking (if changed)? _____

9. Other information the Doctor should know regarding this condition: _____

Patient's Signature: _____ Date: _____

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