FAMILY CHIROPRACTIC & Wellness
Reclaim your health.

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Update Form

Date: _____

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

If you have insurance, please make sure that we have your most recent insurance information!

CURRENT HEALTH STATUS

Describe your main health complaint: _____

Additional complaints: _____

How long have you suffered with your main complaint? _____

How did your symptoms begin? _____

Have you been seen by anyone else for this condition? ___ Yes ___ No If yes, who? _____

What gives you temporary relief? _____

What aggravates your condition? _____

How is your condition progressing? ___ Improving ___ Not Improving ___ Worsening

Describe your pain (circle one): Sharp Shooting Achy Burning Numb Tingling

How severe are your symptoms on a scale of 1-10 (circle one)?

None 1 2 3 4 5 6 7 8 9 10 Worst

Rate your current level of stress on a scale of 1-10 (circle one).

No Stress 1 2 3 4 5 6 7 8 9 10 Very Stressed

Rate your current overall health on a scale of 1-10 (circle one).

Very Unhealthy 1 2 3 4 5 6 7 8 9 10 Optimal Health

Are you pregnant? ___ Yes ___ No

What is your current exercise routine? _____

How is your diet? _____

How many hours do you sleep each night? _____Do you have difficulty falling asleep? ___ Yes ___ No

How much do you prioritize your health? _____

Patient Signature: _____ Date: _____