

# UPDATE FORM

Date: \_\_\_/\_\_\_/\_\_\_

## Personal History

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Gender: Male / Female  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Country: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Sign up for our Email Newsletter? YES NO

## Employer

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 Business Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Type of Work: \_\_\_\_\_

Circle One: Divorced Married Single Separated Widowed

Spouses Name: \_\_\_\_\_ Spouses Employer: \_\_\_\_\_  
 Spouses Occupation: \_\_\_\_\_ Work Phone# : \_\_\_\_\_  
 Ages of Children: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

## Who Is Responsible For Your Bill?

Self  Health Insurance  Work. Comp  Auto Ins.  Medicare  Other (be specific): \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Insured Person's Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Insured Person's Date of Birth: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
 Insured Person's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## CURRENT HEALTH CONDITION

Chief complaint (Why you are here today): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Use the letters below to indicate the type and location of you sensations right now:  
 A=Ache B=Burning N=Numbness  
 P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT

→ → → → → → → →

--When did this complaint/condition begin? \_\_\_\_\_  
 --Has it ever occurred before?  Yes  No  
 If so, When? \_\_\_\_\_  
 --Is the condition:  Auto Related  Work Related  
 No Injury  Other

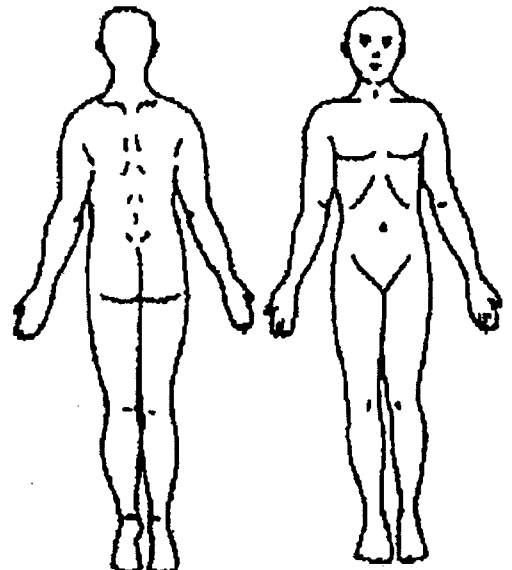
Explain: \_\_\_\_\_  
 \_\_\_\_\_

--Does your pain radiate?  Yes  No  
 If yes, describe: \_\_\_\_\_

--Have you lost time from work? \_\_\_\_\_

--Please Rate Your Symptoms on a Pain Scale (Zero=No pain) (10=Worst Pain):

RESTING: 0 1 2 3 4 5 6 7 8 9 10  
ACTIVE: 0 1 2 3 4 5 6 7 8 9 10



Have you seen other doctors for this condition?  Yes  No If yes, Who? (Name) \_\_\_\_\_

Location of Office: \_\_\_\_\_ Type of Treatment: \_\_\_\_\_

Were you satisfied with the results of your treatment?  Yes  No Explain: \_\_\_\_\_

Are you currently taking any prescription medications?  Yes  No. If yes, please mark or list below (be specific).

- Allergy Medication  Anti-Depressants  Blood Pressure Medication  Insulin  Muscle Relaxers  
 Nerve Pills  Pain Killers  Other (please be specific): \_\_\_\_\_

Do you wear any of the following?  Yes  No. If yes, please mark:  Heel Lifts  Innersoles  Arch Supports  Orthotics

Please list any other conditions you feel we should know about – even if unrelated: \_\_\_\_\_

**What is your goal for care at our office? What would you like to be able to do better and/or easier than you are doing right now?**

**Please Specify the Effect of your Current Condition on the following Daily Activities:**

- |                           |                                    |  |  |  |
|---------------------------|------------------------------------|--|--|--|
| Bending :                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Caring for Infirm Family: | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Carrying Groceries:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Change Posn–Sit–Stand:    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Climb Stairs:             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Driving:                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Ext Computer Use:         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Feeding Yourself:         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Household Chores:         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Kneeling:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lift Children:            | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Lifting (Generalized):    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Daily Pet Care:           | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Reading (Concentration):  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Bathing:        | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Dressing:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Self Care–Shaving:        | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sexual Activities:        | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Sleep:                    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Sitting:           | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Static Standing:          | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Walking:                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| Yard Work:                | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |

**Please Specify the Effect of your Current Condition on your Recreational Activities:**

- |       |                                    |  |  |  |
|-------|------------------------------------|--|--|--|
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |
| _____ | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (limited) | <input type="checkbox"/> Sev Unable to Perform |
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