PATIENT HISTORY UPDATE

Thank you for contacting our office today. Please provide us with a copy of your insurance card so we may update our records.

Name____**Date**_________________

Address____

City____**State**______**Zip**_________

Day Phone________________________ **Eve Phone**_____________________________

Email Address:____

As it has been over a year since we last saw you we must naturally have the most current information regarding your health. Please provide us with the following information

Present Complaint or Crisis? If no current crisis, what is the reason for your visit today?

Major ____

Secondary____

Pain or Problem started on____

What started the problem ? ____

Pains are: ❐ Sharp ❐ Dull ❐ Constant ❐ Intermittent

Is condition worse during certain times of the day? _____________________________

Is this condition interfering with work? ______ Sleep? ______ Routine? ______

Who have you seen for this problem?____

Last Chiropractic Treatment?_________________Chiropractor seen?_______________________

Have you had any recent surgery/illness?_______________________________________

Have you and any injuries/Accidents?____

Dr. Richardson is a Certified Chiropractic Extremity Practitioner. (C.C.E.P.) That is to say he has completed additional course work in areas other than the spine. Please mark down if you are having any problems in the following areas.

- ❑ Jaw pain or clicking (TMJ) R L
- ❑ Shoulder pain R or L
- ❑ Elbow pain R or L
- ❑ Wrist pain R or L
- ❑ Carpal Tunnel R or L

__ Thumb pain R or L
__ Rib pain
__ Hip Pain R or L
__ Knee pain R or L

__ Plantar Fascitis R or L
__ Foot pain R or L
__ Toe Pain R or L
__ Ankle Pain R or L

Signature____

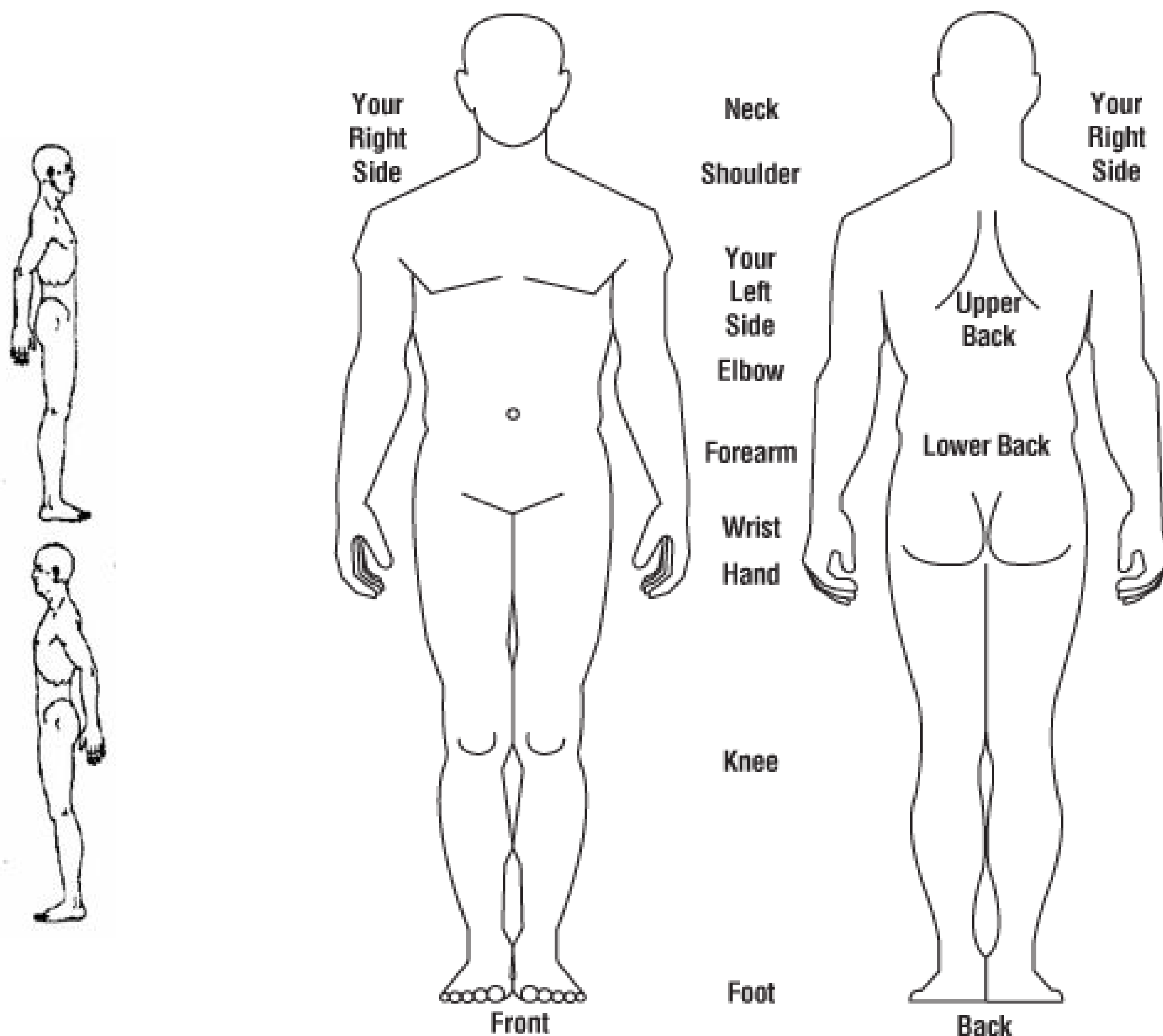
Revised 01/13/2014

Patient Name(Print)__________________________________**Date**_______________

Please draw the location of your pain or discomfort on the images below. Use symbols shown to represent the type(s) of pain :

A= Ache D= Dull S=Stabbing/cutting SH= Sharp B= Burning N= Numb

T= Tingling/Pins and Needles C=Cramping TH=Throbbing O= Other



Do you have the pain 25% 50% 75% 100 % of the day? (Circle one)

How many days a week do you have the pain? 1 2 3 4 5 6 7

Patient Name:____
Date:__________________

Complaint #1: ________________

What is your pain for complaint #1 RIGHT NOW?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL** or **AVERAGE** pain (over the last month)?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your pain at its **BEST** (How close to "no pain" does your pain get at its best)?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What relieves your pain? ____

What is your pain at its **WORST** (How close to "excruciating" does your pain get at its worst)?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? ____

Complaint #2: ________________

What is your pain for complaint #2 **RIGHT NOW**?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your **TYPICAL** or **AVERAGE** pain (over the last month)?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What is your pain at its **BEST** (How close to "no pain" does your pain get at its best)?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What relieves your pain? ____

What is your pain at its **WORST** (How close to "excruciating" does your pain get at its worst)?
No pain ____ Excruciating Pain
0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? ____