PATIENT UPDATE

If it has been awhile since your last visit to our office, please take a few minutes to help us update our records.
If your insurance has changed, please allow our staff to make a copy of your new card.
As always, all information you supply is confidential. We comply with all federal privacy standers.

Please print clearly.

PATIENT INFORMATION

Today's Date (MM/DD/YYYY)

Last Name | First Name | Middle Initial | Nick Name

Address | City | State | Zip

Birth Date (MM/DD/ICY) | Age | Email Address

Home Phone | Cell Phone | Work Phone

Preferred Method of contact?
O Home Phone O Cell Phone
O Work Phone O Email
O Text Message- Reminders

Occupation | Employer Name

Is it ok to call you at work?
O Yes O No

Employer Address | City | State | Zip

SPOUSE'S INFORMATION

Marital Status: O Single O Married O Divorced O Widowed O Separated

Spouse's Name | Spouse's Birth Date | Cell Phone | Work Phone

CONFIDENTIAL INSURANCE INFORMATION

1- Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
O Self O Spouse O Parent

Insured's Employer | Employer's Phone

Employer Address | City | State | Zip

Do you have a secondary Policy? Y / N

2- Insurance Carrier | Policy Number | Primary Care Provider's Name

Insured's Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
O Self O Spouse O Parent

Patient # _____

PURPOSE OF TODAY'S VISIT:

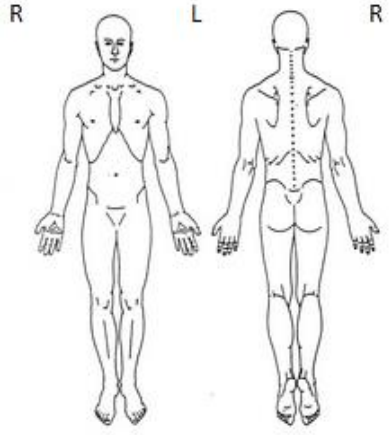
1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the results of: (darken circle) O An accident or injury: O Work O Auto ◯ Other: _____
   O A worsening long-term problem O An interest in: O Wellness O Other: _____
3. Onset: (When did you first notice your current symptoms?) _____
4. Intensity: (How extreme are your current symptoms at their **WORST** & on **AVERAGE**?)

Headache:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Neck Pain:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Mid Back Pain:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Low Back Pain:	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme
Other:_____	**WORST:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme	**AVERAGE:**	Absent 0---1---2---3---4---5---6---7---8---9---10 Extreme

5. Location: (Where does it hurt?) Circle the area(s) on the illustration.



6. Radiation: (Does it affect other areas of your body? Does the pain radiate, shoot or travel?)

_____

*With Questions 7-11, please circle **H** for Headache, **N** for Neck, **M** for Mid Back, **L** for Low Back, and **O** for Other.*

7. Duration & Timing: (When did it start and how often do you feel it?) _____

H N M L O Constant- 76% to 100% of day H N M L O Frequent- 51% to 75% of day
H N M L O Occasional - 26 to 50% of day H N M L O Intermittent - 0% to 25% of day
Are your symptoms worse in the morning, afternoon, or evening? Yes / No If Yes, when: _____

8. Quality of symptoms: (What does it feel like?)

H N M L O Dull	H N M L O Stabbing	H N M L O Burning	H N M L O Radiating
H N M L O Tingling	H N M L O Throbbing	H N M L O Numbness	H N M L O Aching
H N M L O Sharp	H N M L O Cramps	H N M L O Deep	H N M L O Stiffness

H N M L O Other: _____ H N M L O Other: _____

9. Aggravating Factors: (What makes it worse?)

H N M L O Sitting	H N M L O Sleeping	H N M L O Looking up	H N M L O Typing
H N M L O Lifting	H N M L O Twisting	H N M L O Driving	H N M L O Stair Stepping
H N M L O Reaching	H N M L O Lying Face Up	H N M L O Lying Face Down	H N M L O Sit to Stand
H N M L O Rest	H N M L O Exercise	H N M L O Bending	H N M L O Straining
H N M L O House Chores	H N M L O Walking	H N M L O Coughing	H N M L O Movement
H N M L O Standing	H N M L O Sneezing	H N M L O Looking down	H N M L O Scooping

H N M L O Other: _____ H N M L O Other: _____

10. Relieving Factors: (What makes it feel better?)

H N M L O Sitting	H N M L O Standing	H N M L O Lying	H N M L O Knees Bent Up	H N M L O Support
H N M L O No Movement	H N M L O Heat	H N M L O Ice	H N M L O Analgesic Topical: ie: Biofreeze, Bengay, Icy Hot	
H N M L O Ibuprofen	H N M L O Medication	H N M L O Rest	H N M L O Stretching/Exercise	H N M L O Adjustments
H N M L O Massage	H N M L O Other: _____		H N M L O Other: _____	

11. Prior Interventions: (What have you done to relieve the symptoms?)

H N M L O Prescription Medication	H N M L O Physical Therapy	H N M L O Ice	H N M L O Drugs	H N M L O Acupuncture
H N M L O Over-the-Counter	H N M L O Chiropractic	H N M L O Heat	H N M L O Massage	
H N M L O Homeopathic Remedies	H N M L O Surgery	H N M L O Other: _____	H N M L O Other: _____	

12. What else should Dr. Amy Nedrow know about your current condition? _____

_____

13. How does your current condition interfere with your:

Work or Career: _____

Recreational Activities: _____

Household Responsibilities: _____

Personal Relationships: _____

Consultation Notes:

Reviewed with the patient on _____/_____/_____. _____

Patient # _____

Activities of Daily Living: How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O
Rising out of Chair	O	O	O	O
Standing	O	O	O	O
Walking	O	O	O	O
Lying Down	O	O	O	O
Bending Over	O	O	O	O
Climbing Stairs	O	O	O	O
Using a Computer	O	O	O	O
Getting In/Out of Car	O	O	O	O
Driving a Car	O	O	O	O
Looking over Shoulder	O	O	O	O
Caring for Family	O	O	O	O
Grocery Shopping	O	O	O	O
Household Chores	O	O	O	O
Lifting Objects	O	O	O	O
Reaching Overhead	O	O	O	O
Showering or Bathing	O	O	O	O
Dressing Myself	O	O	O	O
Love Life	O	O	O	O
Getting to Sleep	O	O	O	O
Staying Asleep	O	O	O	O
Concentrating	O	O	O	O
Exercising	O	O	O	O
Yard Work	O	O	O	O

Please list your current Medications below including what condition you are taking it for, as well as the dosage and times per day:

Medication Name:	Dosage:	Times/Day:	Condition:

Females: Are you pregnant or nursing: Yes No If you are pregnant, when are you due: _____

Have there been any changes in your health since your last visit? (ie: Surgeries, Major Illness, Motor Vehicle Accidents, etc.)
O Yes O No If yes, please list below:

_____

_____

_____

_____

Consultation Notes:

Reviewed with the patient on _____/_____/_____. _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with our business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be held solely responsible for any balance not paid by your insurance company, and you will be responsible for legal fees and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changed to the information that I have knowledge and understand that it is my responsibility to inform of any changes to the information that I have provided.

Patient Signature: _____ Date: _____