Back Pain Relief Chiropractic, P.C.

Dr. Thomas M. Andrews, D.C.

1108 S. 13th Street, Artesia, NM 88210

Patient Information Update Form, page 1 of 1

Name: _____ Date: _____

Please notify us of any changes to your address, phone number, email, insurance, etc.:_____

_____

Please List any accidents, injuries, falls, traumas, surgeries, etc., since your last visit: _____

_____

YOUR CURRENT CHIEF COMPLAINT AND HEALTH HISTORY

If you have more than one complaint, please complete the next page. Use one section for each complaint.

Height: _____ Weight: _____ Are you Pregnant? _____

What is your **CHIEF / MAIN** complaint? _____

How long have you had this condition? _____

Is this the FIRST time you have had this condition? _____If No, last episode: _____

What caused this to occur? _____

Does the pain radiate to any other part of your body? _____

On a scale of 1-10 how would you rate the intensity of your pain? _____

Quality of Pain / Symptom: (circle those that apply): Sharp Stabbing Dull Ache Throbbing Numb

Other: _____

When you are awake, how often is the pain present?: 0-25% of time 26-50% 51-75% Constant

Does anything give you relief from your pain? _____

Does anything aggravate the pain? _____

Do you feel better during certain times of the day? _____

Since the pain/symptom began; has it been getting better, staying the same, or getting worse? _____

Have you ever been treated by ANY other doctor for this condition? _____

If yes, by whom?: _____How long ago?: _____

What were the results? _____

Patient Signature: _____ Date: _____

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ADDITIONAL CURRENT COMPLAINTS AND HEALTH HISTORY

Name: _____ Date: _____

Please describe your health issue: _____

How long have you had this condition? _____

Is this the FIRST time you have had this condition? _____If No, last episode: _____

What caused this to occur? _____

Does the pain radiate to any other part of your body? _____

On a scale of 1-10 how would you rate the intensity of your pain? _____

Quality of Pain / Symptom: (circle those that apply): Sharp Stabbing Dull Ache Throbbing _____

When you are awake, how often is the pain present?: 0-25% of time 26-50% 51-75% Constant

Does anything give you relief from your pain? _____

Does anything aggravate the pain? _____

Do you feel better during certain times of the day? _____

Since the pain/symptom began; has it been getting better, staying the same, or getting worse? _____

Have you ever been treated by ANY other doctor for this condition? _____

If yes, by whom?: _____How long ago?: _____

What were the results? _____

Patient Signature: _____ Date: _____

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Please describe your health issue: _____

How long have you had this condition? _____

Is this the FIRST time you have had this condition? _____If No, last episode: _____

What caused this to occur? _____

Does the pain radiate to any other part of your body? _____

On a scale of 1-10 how would you rate the intensity of your pain? _____

Quality of Pain / Symptom: (circle those that apply): Sharp Stabbing Dull Ache Throbbing _____

When you are awake, how often is the pain present?: 0-25% of time 26-50% 51-75% Constant

Does anything give you relief from your pain? _____

Does anything aggravate the pain? _____

Do you feel better during certain times of the day? _____

Since the pain/symptom began; has it been getting better, staying the same, or getting worse? _____

Have you ever been treated by ANY other doctor for this condition? _____

If yes, by whom? _____How long ago? _____

What were the results? _____

Patient Signature: _____ Date: _____