

# UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Your Last Name Your Social Security Number Birth Date (MM/DD/YYYY) Age

Your First Name Your Middle Name (or Initial) Gender Race

Gender  
 Male  Female

Address Marital Status  Married  Single  Divorced  Widowed  Separated Ethnicity

City State/Province ZIP/Postal Code Preferred Language

Home Phone Cell Phone Spouse's Name

Email Address Child's Name and Age

Emergency Contact Emergency Contact's Phone Child's Name and Age

Your Occupation Child's Name and Age

Your Employer Work Phone

Address May we contact you at work?  Yes  No

City State/Province ZIP/Postal Code Preferred method of contact?  Home Phone  Cell Phone  Work Phone  Email

Primary Care Provider's Name

Insurance Carrier Policy Number

Insured's Last Name Birth Date (MM/DD/YYYY) Who carries this policy?  Self  Spouse  Parent

Insured's First Name Insured's Middle Name (or Initial)

Insured's Employer

Address

City State/Province ZIP/Postal Code Employer's Phone

I certify that any changes to my personal information have been updated above for your records. \_\_\_\_\_  
Signature

UPDATED CONTACT INFORMATION

# UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) \_\_\_\_\_

Patient Number  
 (office use only)

Your Last Name \_\_\_\_\_

Your First Name \_\_\_\_\_

Your Middle Name (or Initial) \_\_\_\_\_

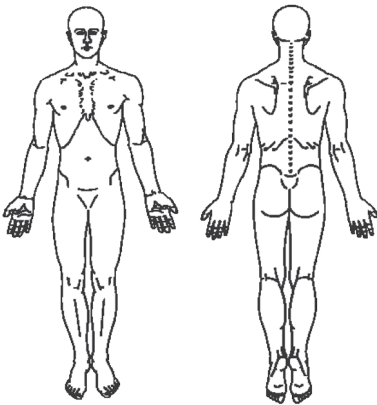
I have new contact information

Please select one:

- Progress evaluation** – I've been under active care and this is a periodic reevaluation.
- New condition** – I've been under care and a new or returning condition has emerged.
- Maintenance patient** – I'm under maintenance care with a new or returning health issue.
- Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: \_\_\_\_\_

**1. Location** (Where does it hurt?)  
 Circle the area (s) on the illustration.



**2. Quality of symptoms** (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other \_\_\_\_\_

**3. Intensity** (How extreme are your current symptoms?)



**4. Duration and Timing** (When did it start and how often do you feel it?)

- Constant  Come and goes.
- When did it start and how often? \_\_\_\_\_

**5. Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

**6. Aggravating or relieving factors** (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? \_\_\_\_\_  
 What tends to lessen the problem? \_\_\_\_\_

**7. Prior interventions** (What have you done to relieve the symptoms?)

- Prescription medication  Surgery  Ice
- Over-the-counter drugs  Acupuncture  Heat
- Homeopathic remedies  Chiropractic  Other \_\_\_\_\_
- Physical therapy  Massage \_\_\_\_\_

**8. What else should Wexler Chiropractic know about your current condition?** \_\_\_\_\_

**9. Review of systems** (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
<b>a. Musculoskeletal System</b> – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>b. Neurological System</b> – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>c. Cardiovascular System</b> – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>d. Respiratory System</b> – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>e. Digestive System</b> – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>f. Sensory System</b> – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>g. Skin System</b> – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>h. Endocrine System</b> – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>i. Genitourinary System</b> – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>j. Constitutional System</b> – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**10. Illnesses, operations, injuries or treatments since your most recent evaluation with us:** \_\_\_\_\_

**This updated patient history is for:**

- Current Patient  
Periodic Re-evaluation
- Current Patient  
Additional Complaint/  
Exacerbation
- Maintenance Patient (circle one)  
Exacerbation  
Re-Occurrence  
New Episode
- Inactive Patient (circle one)  
Exacerbation  
Re-Occurrence  
New Episode

Consultation Notes

**UPDATED PATIENT HISTORY**

Doctor's Initials \_\_\_\_\_

**11. Medications (please list all prescription and over-the-counter):** \_\_\_\_\_

\_\_\_\_\_  
**Patient name**

**12. Social History** (Tell Wexler Chiropractic about your health habits and stress levels.)

\_\_\_\_\_  
**Patient Number**  
(office use only)

Alcohol use     Daily     Weekly    How much? \_\_\_\_\_  
Coffee use     Daily     Weekly    How much? \_\_\_\_\_  
Tobacco use    Daily     Weekly    How much? \_\_\_\_\_  
Exercising     Daily     Weekly    How much? \_\_\_\_\_  
Pain relievers  Daily     Weekly    How much? \_\_\_\_\_  
Soft drinks    Daily     Weekly    How much? \_\_\_\_\_  
Water intake  Daily     Weekly    How much? \_\_\_\_\_  
Hobbies: \_\_\_\_\_

Prayer or meditation?     Yes     No  
Job pressure/stress?     Yes     No  
Financial peace?     Yes     No  
Vaccinated?     Yes     No  
Mercury fillings?     Yes     No  
Recreational drugs?     Yes     No

**13. 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**14. Is there anything else Wexler Chiropractic should know about your current condition, your progress or ways your current condition is affecting your life?**

\_\_\_\_\_

**To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

**If the patient is a minor child, print child's full name:** \_\_\_\_\_

Consultation Notes

\_\_\_\_\_  
**Doctor's Initials**

**Wexler Chiropractic**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (MM/DD/YYYY)