DISCOVER CHIROPRACTIC & WELLNESS
PATIENT UPDATE

Name _____ Home Phone (_____) _____

Address _____
Street or Box Number City State Zip

Occupation _____ Employer _____

Employer's Address _____ Work Phone (_____) _____

Spouse _____ Spouse's Employer _____

Purpose of this appointment: _____

Is this the same problem you were originally under care for? ( ) Yes ( )No

If yes, are there any additional symptoms? _____

Other doctors seen for this condition: _____

What medications or drugs are you taking? _____

If female, are you taking birth control pills? ( ) Yes ( ) No Pregnant? ( ) Yes ( ) No

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Discover Chiropractic & Wellness to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

_____
Patient Signature (or Guardian Signature Authorizing Care) Date

INSURANCE

Company_____Insured_____SS# _____

1. What is your major symptom? _____

2. When was the first time you noticed this problem? _____

   How did it occur? _____

   Has it become worse recently? _____ If yes, when and how? _____

3. How frequent is the condition? _____

   How long does it last? _____

4. Have you ever had the same or a similar condition: ☐ Yes ☐ No

   If yes, when and describe: _____

5. Are there any conditions or symptoms you have that may be related to your major symptom?

   _____

6. If pain is involved, is it – sharp, dull, throbbing, stabbing, aching, burning, tingling, shooting?

   (other) _____

7. Is there anything you can do which seems to provide relief? _____

   _____

8. What makes the problem worse? _____

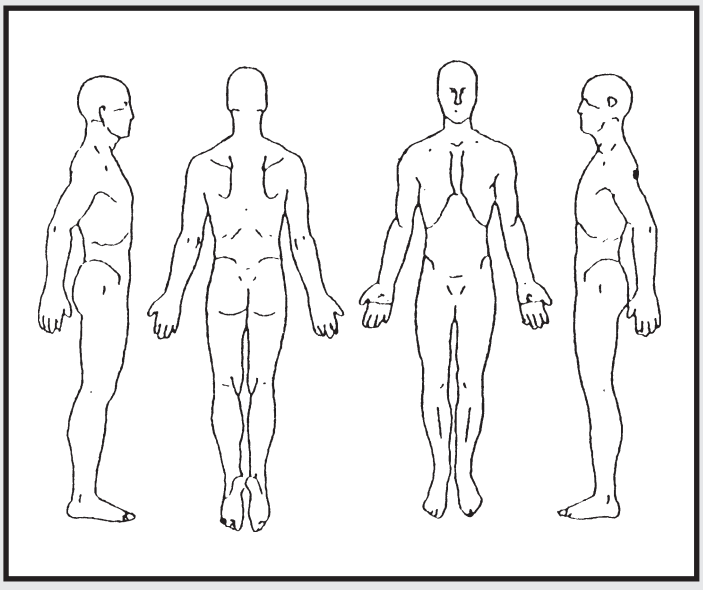
9. List accidents, illness, surgeries, or broken bones you have had since your last visit. _____

   _____

IMPORTANT!

10. **Please Mark Your Symptom Areas**

After you print or come into office mark symptom in the areas below with a numerical pain value



11. **Rate the Severity of Your Condition**