– Patient Update –

Name: _____

CURRENT CONTACT INFORMATION:

Cell Phone: _____

Home Phone: _____

Email Address: _____

Home Address: _____

In Case of Emergency (Name and phone number): _____

WHAT HAS CHANGED SINCE LAST VISIT?

NEW MEDICATIONS?

NEW INJURIES?

PATIENT CURRENT CONDITIONS:

Reason for your visit? _____

Where is the pain located: _____

When did your symptoms appear? _____

Is this condition getting? ☐Better ☐Worse ☐No Change

Please check the types of pain that apply to you:

☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling

☐Cramps ☐Stiffness ☐Swelling ☐Other _____

Rate the severity of pain on a scale of **1** (least) to **10** (severe): _____

Is the pain: ☐Consistent ☐Come and go

Does it interfere with you?

☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other _____

Please check the following movements or activities that are painful for you to perform:

☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other _____

*In the event that we do not receive **24 hours notice** of your intent to change your appointment time, a cancellation fee will be imposed as follows.* ***Please note, Monday appointments require 48 hours cancellation notice as our office is closed on Sundays. I am aware there is a fee of $100.00 for missed or late canceled sports medicine or chiropractic appointments.***

Your signature below signifies that you have read and agree to our cancellation policy.

Patient Signature: _____ Date: _____