CHIROPRACTIC PARTNERS, S.C.

AUTO AND WORK INJURIES ♦ SPORTS INJURIES ♦ FAMILY PRACTICE ♦ NUTRITION AND WELLNESS CARE♦ MASSAGE AND PHYSIOTHERAPY

UPDATE

NAME:_____DATE_____

CURRENT ADDRESS:_____

CITY:_____STATE_____ZIP_____

TELEPHONE NUMBER:_____

IN ORDER FOR US TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGUARDING YOUR PRESENT HEALTH TO BRING OUR ORIGINAL CASE HISTORY UP TO DATE. WOULD YOU PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION.

PLEASE PRINT

1. MY PRESENT SYMPTOMS ARE _____
2. RECENT FALLS _____
3. RECENT SURGERY _____
4. RECENT ACCIDENTS _____
5. LAST PHYSICAL _____
6. LAST ADJUSTMENT_____
7. SINCE I LAST SAW YOU, I HAVE BEEN SEEN BY DR. _____

   FOR _____
8. DO YOU HAVE INSURANCE? _____YES _____NO WHAT KIND OR COMPANY?_____
9. HAVE YOU BEEN IN A RECENT ACCIDENT? _____YES _____NO _____

   SINCE YOUR LAST TREATMENT BY US? _____YES _____NO _____
10. PATIENT'S COMMENTS:_____

    _____

    _____

    _____

I UNDERSTAND THAT IF I AM ACCEPTED AS A PATIENT OF THIS CLINIC, I AM AUTHORIZING THE STAFF TO PROCEED WITH ANY FURTHER TREATMENT THAT MAY BE NECESSARY IN MY CARE. FURTHER MORE, ANY RISKS INVOLVING SUCH TREATMENT WILL BE EXPLAINED TO ME UPON REQUEST.

PATIENT SIGNATURE_____DATE_____

PARENT/GUARDIAN AUTHORIZES CARE OF MINOR_____DATE_____