PATIENT INFORMATION UPDATE FORM

*Please inform us if you have recently been in a **motor vehicle accident** or a **work-related injury***

In order to UPDATE YOUR PATIENT RECORDS and provide some IMPORTANT INFORMATION FOR YOUR DOCTOR, we ask that you CAREFULLY answer the following questions:

Name: _____ Date: _____ **For Office Use**
Address: _____
Phone #: _____ Cell # _____
Work #: _____ e-mail _____

1. Are you coming for the same problem? **YES / NO**
2. What is your chief complaint? _____

_____

3. How did it happen? _____

_____

4. When did it happen? _____
5. Describe your pain: (sharp/burning/constant/throbbing, etc.) _____

_____

6. Since the pain started, is it getting: ☐ Better ☐ Worse ☐ No Change
7. What is your pain intensity in a scale of 0 – 10, with 10 being the worst pain you can imagine and 0 being no pain?
8. What makes the pain worse? (examples: bending, coughing, sitting or sleeping)

_____

9. What makes the pain better? (examples: ice, heat, medication) _____

_____

10. Is the pain local or does it move anywhere? If so, where? _____

_____

11. At the time that this began, did you notice other symptoms/problems? (bowel / bladder dysfunction, numbness, difficulty breathing) _____

_____

12. List any accidents or injuries since your last visit: _____

_____

13. Have there been any changes to your health or life since your last visit?

_____

Other comments or secondary problems: _____

_____