**Cumming Chiropractic Center, P.C.**

# What's New

**Patient Update**

## 1 ABOUT YOU

**Today's Date:**_____

**Name:**_____
Last First MI

**Address:**_____

_____
City State Zip

**Home Phone: (  )**_____

**(  )**_____ **(  )** _____
Cell phone Office phone

**E-mail:**_____

**Employer:**_____

**Occupation:**_____**How long?**_____

**Marital Status: M D W S**

**Spouse's Name**_____

## 2 INSURANCE INFO

**Do you have Health Insurance?**

**❑No ❑Yes** ***If NO, please continue to block 3.***

**Co. Name**_____

**Insured's Name**_____

**Relation:**_____**Date of Birth**_____

**Insured's Employer:**_____

initial **I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this time).**

**Please provide insurance card(s) with this form.**

## 3 REASON FOR VISIT

**Reason for today's visit: ❑Emergency ❑New Injury ❑Old Injury ❑Chronic pain ❑ Wellness**

**Rate your pain: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹ When did condition occur?** _____**(most recent)**

**Did your condition occur during: ❑Routine/Household activity ❑Sports/play ❑Auto accident ❑Other**_____

**Describe health concern**_____

_____

## 4 UPDATED HEALTH HISTORY

**What medications are you taking? (please include over-the-counter drugs, vitamins)**_____

_____

**Please list any NEW injury's since your last visit: ❑auto accident ❑falls ❑other**_____

**Please explain**_____

**Have you had any surgery since your last visit? ❑No ❑Yes Explain, give dates**_____

_____

**I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided**

**Signature**_____ **Date**_____/_____/_____

# HEALTH REVIEW

**Name**_____ **Date of Birth**_____ **Today's Date**_____

**Please check all symptoms you have experienced.**

**CARDIOVASCULAR**
- ☐ general swelling
- ☐ swelling in legs
- ☐ swelling in face / eyes
- ☐ chest pain
- ☐ heart "jumps"/ pounds
- ☐ rapid heart beat/ irreg
- ☐ hypertension
- ☐ heart attack
- ☐ harden of arteries
- ☐ pain over the heart
- ☐ blood vessel disease (phlebitis, etc.)
- ☐ any family member had stroke

**VERTEBROBASILAR**
- ☐ double vision / blurred
- ☐ loss of coordination
- ☐ irregular muscle movement
- ☐ ringing in ears
- ☐ high blood pressure
- ☐ areas of muscle weakness
- ☐ dizziness with nausea
- ☐ dizziness without nausea
- ☐ fainting spells
- ☐ loss of memory
- ☐ inability to form words
- ☐ had a stroke
- ☐ periods of blindness

**WOMEN ONLY**
- ☐ painful period
- ☐ spotting
- ☐ vaginal discharge
- ☐ premenstrual symptoms
- ☐ irregular periods
- ☐ birth control
- ☐ lumps in breast

# pregnancies _____
# deliveries _____

**MUSCULOSKELETAL**

**HEAD**
- ☐ frequent headache
- ☐ severe headache
- ☐ head feels heavy
- ☐ vertigo
- ☐ light headedness
- ☐ loss of smell
- ☐ loss of taste
- ☐ loss of balance
- ☐ dizziness

03/07

**NECK**
- ☐ neck pain / stiffness
- ☐ neck pain with movement
- ☐ swelling in neck
- ☐ pinched nerve in neck
- ☐ neck feels out of place
- ☐ muscle spasms in neck
- ☐ grinding sounds in neck
- ☐ popping sounds in neck

**SHOULDERS**
- ☐ pain in shoulder R-L-Both
- ☐ pain across shoulders
- ☐ tension in shoulders
- ☐ muscle spasms in shoulders
- ☐ can't raise arm Rt / Lt
  - ☐ above shoulder level
  - ☐ over head

**ARMS & HANDS**
- ☐ pain in upper arm R-L-Both
- ☐ pain in forearm
- ☐ pain in hand R-L-Both
- ☐ pain in fingers R-L-Both
- ☐ sensation of pins & needles
  - ☐ arms
  - ☐ in fingers
- ☐ fingers go to sleep
- ☐ cold hands
- ☐ swollen joints in fingers
- ☐ sore joints in finger
- ☐ loss of grip strength R - L- Both

**MIDBACK**
- ☐ mid back pain
- ☐ sharp stabbing pain
- ☐ dull ache
- ☐ pain front to back
- ☐ pain kidney area
- ☐ muscle spasms in mid back area

**LOWBACK**
- ☐ low back pain
- ☐ back feels out of place
- ☐ muscle strains

**HIPS, LEGS & FEET**
- ☐ pain in buttocks
- ☐ pain down leg R-L-Both
- ☐ knee pain R-L-Both
- ☐ leg cramps R-L-Both
- ☐ pins &needles in legs
- ☐ numbness in legs /toes
- ☐ cold feet
- ☐ swollen ankles / feet

**SKIN/NAILS/HAIR**
- ☐ eczema
- ☐ itchy / dry skin
- ☐ dry scalp
- ☐ psoriasis
- ☐ yellow skin
- ☐ bruise easily
- ☐ pale skin

**EYES**
- ☐ blurring of vision
- ☐ double vision
- ☐ eyes fatigue easily
- ☐ excessive tearing
- ☐ lack of tearing
- ☐ light bothers eyes
- ☐ excessive itching
- ☐ pain in eyeball

**EARS**
- ☐ loss of hearing
- ☐ pain in ears
- ❑ ear infections
- ☐ discharge from ears
- ☐ vertigo
- ☐ ringing in ears

**NOSE NASOPHARYNX SINUSES**
- ☐ unusual nasal discharge
- ☐ nose bleeds
- ☐ pressure over eyes
- ☐ pressure under eyes
- ☐ obstruction of nose
- ☐ frequent colds
- ☐ sinusitis
- ☐ nasal allergies
- ☐ loss of sense of smell

**MOUTH AND THROAT**
- ☐ pain in mouth
- ☐ pain of throat
- ☐ bleeding gums
- ☐ cavities
- ☐ abscessed teeth
- ☐ difficulty swallowing
- ☐ changes in voice

**VENERAL DISEASE**
- ❑ AIDS
- ❑ syphilis
- ❑ gonorrhea
- ❑ other

**RESPIRATORY**
- ☐ shortness of breath
- ☐ can't breath while lying down
- ☐ can't sleep while lying down
- ☐ dry cough
- ☐ productive cough
- ☐ coughing up blood
- ☐ wheezing
- ❑ asthma / bronchitis

**GASTROINTESTINAL**
- ☐ poor appetite
- ☐ indigestion / heartburn
- ☐ can't eat some foods
- ☐ nausea & vomiting
- ☐ jaundice
- ☐ abdominal pain
- ☐ change in bowel habit
- ☐ diarrhea
- ☐ constipation
- ☐ hemorrhoids

**GENITOURINARY**

Urination is: ❑ frequent ❑ normal ❑ infrequent

Urine amount is: ❑ high ❑ normal ❑ low

- ❑ need to get up at night to urinate
- ❑ abnormal intense desire to urinate
- ❑ difficulty starting urination
- ❑ decreased output
- ❑ pain urinating
- ❑ dribbling
- ❑ blood in urine
- ❑ cloudy urine
- ❑ lack of bladder control
- ❑ prostate problems (male)

**SOCIAL HISTORY**
- ❑ smoking / tobacco use
- ❑ alcohol use

Diet is: ❑ balanced ❑ not balanced

Sleep is: ❑ sufficient ❑ insufficient

Exercise is: ❑ sufficient ❑ insufficient

My family stress is: ❑ severe ❑ moderate ❑ minimal

How do you like your work? ❑ very much ❑ it's ok ❑ hate it

My job stress is: ❑ severe ❑ moderate ❑ minimal

- ❑ nervousness
- ❑ fatigue
- ❑ depression
- ❑ generally feel run-down