Patient Update Form

Please let our staff know of any changes in your health status, contact information, or insurance. Do not skip any questions. This is an important part of establishing medical necessity. If you have any questions, please ask one of our team members.

Please bring any old or new X-Ray CDs or MRI reports. It may help the doctor.

Date _____ **First Name** _____ **Last Name** _____

Birth Date: MM/DATE/YEAR _____ **Cell Phone** _____ **Email** _____

Street Address _____ **City** _____

State/Province _____ **Zip Code** _____ **Marital Status** _____

Purpose of this appointment:

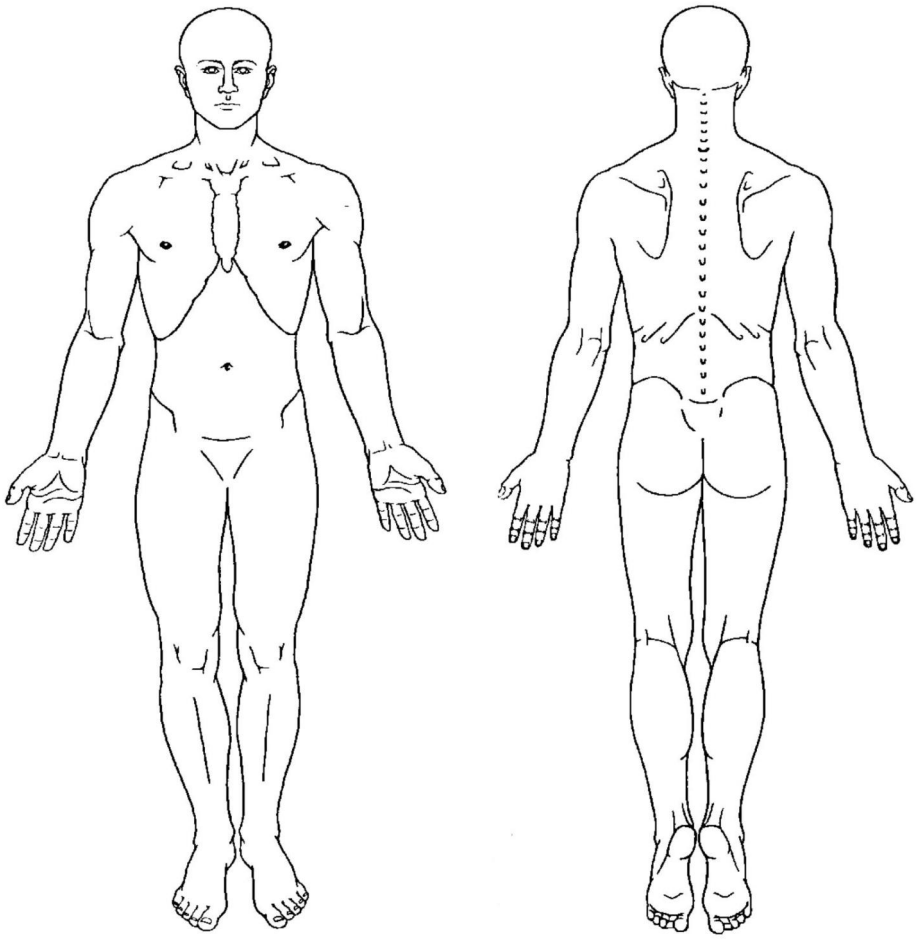
◯ New Condition ◯ Flare-up ◯ Chronic Discomfort ◯ Injury ◯ Other

If other, please explain: _____

Mark any and ALL areas on the diagram below that bother you or that you want to be treated.

(Please use your mouse or touchscreen to mark)

*



Starting with your primary complaint, list the symptom(s) you marked on the diagram above that you want treated. Example: Headaches, Neck Pain, Right Shoulder Pain, Upper Back Pain, Wrist Pain, Low Back Pain, Hip Pain, Foot Pain, etc.

Primary Complaint / Symptom(s) that prompted me to seek care today is:

On a scale from 0 to 10, with 10 being the worst, which number best describes your symptom(s) at its worst lately?

◯ 0 ◯ 1 ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 ◯ 7
◯ 8 ◯ 9 ◯ 10

What percentage of the day do you have the above symptom(s)?

◯ Constant - 100% (all day) ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Secondary Complaint / Symptom(s) that prompted me to seek care today is:

On a scale from 0 to 10, with 10 being the worst, which number best describes the symptom(s) at its worst lately?

◯ 0 ◯ 1 ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 ◯ 7
◯ 8 ◯ 9 ◯ 10

What percentage of the day do you have the above symptom(s)?

◯ Constant - 100% (all day) ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Additional Complaint / Symptom(s) that prompted me to seek care today is:

On a scale from 0 to 10, with 10 being the worst, which number best describes the symptom(s) at its worst lately?

◯ 0 ◯ 1 ◯ 2 ◯ 3
◯ 4 ◯ 5 ◯ 6 ◯ 7
◯ 8 ◯ 9 ◯ 10

What percentage of the day do you have the above symptom(s)?

◯ Constant - 100% (all day) ◯ Frequent - 75% ◯ Intermittent - 50% ◯ Occasional - 25%

Choose how your symptom(s) began?

☐ Gradual ☐ Sudden

What is the start date or number of days, weeks or months your symptom(s) began?

Is your condition caused by trauma

◯ No ◯ Yes

If yes, please explain and list date or approximate year:

Please check and explain what caused your symptom(s)?

☐ Not sure ☐ Sports Injury ☐ Auto Accident ☐ After a slip / fall
☐ Work Injury ☐ Yard work ☐ Reaching ☐ Prolonged illness
☐ Household chores ☐ After a poor night's sleep ☐ After a long drive / flight ☐ Sitting too long
☐ Standing too long ☐ After lifting an object ☐ Other

If other, please explain:

What makes your symptom(s) worse? (Check all that apply)

☐ Bending Neck Forward ☐ Bending Neck Backward ☐ Tilting Head to Left ☐ Tilting Head to Right
☐ Turning Head to Left ☐ Turning Head to Right ☐ Bending Forward at Waist ☐ Bending Backward at Waist
☐ Tilting Left at Waist ☐ Tilting Right at Waist ☐ Twisting Left at Waist ☐ Twisting Right at Waist
☐ Sitting ☐ Standing ☐ Getting Up from Sitting ☐ Any Movement
☐ Changing Positions ☐ Walking ☐ Running ☐ Driving
☐ Climbing ☐ Lifting ☐ Other

If other, please explain:

What makes your symptom(s) better? (Check all that apply)

☐ Nothing ☐ Exercise ☐ Rest ☐ Massage ☐ Ice
☐ Heat ☐ Stretching ☐ Walking ☐ Pain Medication ☐ Muscle Relaxers
☐ Physical Therapy ☐ Chiropractic ☐ Other

If other, please explain:

Describe the quality of your symptom(s) (Check all that apply)

- ☐ Sharp
- ☐ Shooting
- ☐ Dull
- ☐ Tight
- ☐ Achy
- ☐ Stiff
- ☐ Burning
- ☐ Spasms
- ☐ Throbbing
- ☐ Tingling
- ☐ Stabbing
- ☐ Numb
- ☐ Other

If other, please explain:

Activities of Daily Living

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Sitting to Standing

- ☐ No Effect / Sin efecto
- ☐ Painful (can do) / Doloroso (puedo hacer)
- ☐ Painful (limits) / Doloroso (limitado)
- ☐ Unable to Perform / No puedo Realizar

Climbing

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Driving

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Extended Computer Use

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Getting Dressed

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Lifting Children/Groceries

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Sexual Activities

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Sleep

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Static Sitting

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Static Standing

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Walking

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Washing/Bathing

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

Yard Work

- ☐ No Effect
- ☐ Painful (can do)
- ☐ Painful (limits)
- ☐ Unable to Perform

When is the symptom(s) worse? (Check one)

- ☐ Unaffected by time of day
- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night

Does the symptom(s) radiate to another part of your body?

- ◯ Yes
- ◯ No

If yes, where does the symptom(s) radiate?

Has this condition occurred before?

- ◯ Yes
- ◯ No

Have you seen other doctors for your symptom(s)?

- ◯ Yes
- ◯ No

If yes, list doctors, approximate visit date, diagnosis, and provide us with X-rays CDs and MRI reports if possible.

Previous Treatment for this Condition

- ☐ None
- ☐ Trigger Point Injections
- ☐ Anti-Inflammatory Medication
- ☐ Cortisone Injections
- ☐ Chiropractic
- ☐ Pain Medication
- ☐ Massage
- ☐ Muscle Relaxers
- ☐ Acupuncture
- ☐ Physical Therapy
- ☐ Other

If other, please explain:

Please check each of the diseases or conditions that you have now or in the past:

- ☐ Aneurysm
- ☐ Metal implants
- ☐ Diabetes
- ☐ ALS
- ☐ Rheumatoid arthritis
- ☐ Blood clots
- ☐ Recent Fever
- ☐ Multiple Sclerosis
- ☐ Spinal fracture
- ☐ Pacemaker
- ☐ Covid-19
- ☐ Cancer
- ☐ Spinal surgery
- ☐ History of seizures
- ☐ Lyme Disease
- ☐ Sudden Weight Loss
- ☐ Scoliosis
- ☐ Strokes/TIAs
- ☐ Urinary Incontinence
- ☐ None of the above

Please explain any of the above diseases or conditions that you checked above (ie. resolved, when diagnosed, etc.):

Is there is anything else in your past medical history that you feel is important to your care here?

For Women Only: Are you pregnant or have signs of pregnancy?

- ◯ Yes
- ◯ No

Authorization for Care

To set clear expectations and communication to help you get the best results in the shortest amount of time, read the statement below and sign if you agree.

I instruct the chiropractor to deliver the care that, in their professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. I may request a copy of the HIPAA Notice of Privacy Practices and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. I grant permission to be called to confirm or reschedule an appointment and to be sent texts, occasional cards, letters, emails, or health information to me as an extension of my care in this office. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. If my insurance will be billed, I authorize payment to be made directly to Ridge Chiropractic Center for all benefits that may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this form or copies thereof for the purpose of processing claims and effecting payments and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that

I will remain financially responsible for any and all covered or non-covered services I receive at this office. All first visit charges are payable when services are rendered since it is impossible to determine insurance coverage without a diagnosis of severity.

☐ I have read and fully understand the above and certify that the information I have provided is true and correct to the best of my knowledge, and I will not hold the doctor or any staff member at Cumming Chiropractic Center responsible for any errors or omissions that I may have made on this form. I do hereby authorize the doctor to treat my child or me in accordance with this state's statutes.

Signature

Date Signed

_____

Printed Name

Email

_____ _____

Signature of Legal Representative if patient a minor

Relationship (e.g. Guardian or Parent)

_____ _____