Mid-America Family Chiropractic, LLC

Patient Information Update

Date: _____/_____/_____

Patient Last Name: _____ First Name: _____ M.I. _____

Current Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Email Address: _____ Date of Birth: _____/_____/_____

Purpose of this visit? (i.e. lower back pain)

_____

_____

How long have you suffered from this complaint? _____

Current pain level (0 = no pain, 10 = unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Have you had any recent falls, accidents or other injuries within the last 6 months? ___ No ___ Yes

If yes, please explain: _____

_____

Have you had any surgeries or major health issues within the last 6 months? ___ No ___ Yes

If yes, please explain: _____

_____

_____

Are you taking any medications currently? ___ No ___ Yes

If yes, please explain: _____

_____

Any change in health insurance? ___ No ___ Yes

_____

Are you pregnant? ___ No ___ Yes

Patient Signature: _____ Date: _____/_____/_____

Provider Signature: _____ Date: _____/_____/_____