KANADY
CHIROPRACTIC

PATIENT INFORMATION UPDATE

Name: _____ Date: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Cell phone number: _____

Home or another phone: _____

Please initial to authorize voicemails left at these phone numbers: _____

Email: _____

Marital status: ○ Married ○ Single ○ Divorced ○ Widowed

Place of employment: _____

Occupation: _____

Address: _____

Phone number: _____

Insurance company: _____

Primary member name on insurance policy: _____

Patient relationship to policy holder: _____

Date of birth of policy holder: _____

Secondary insurance (if applicable): _____

Primary member name on insurance policy: _____

Patient relationship to policy holder: _____

Date of birth of policy holder: _____

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Date: _____

UPDATED PATIENT HISTORY

_____ _____ _____

First Name **Last Name** **MI**

☐ I have new contact information

Please select one of the following:

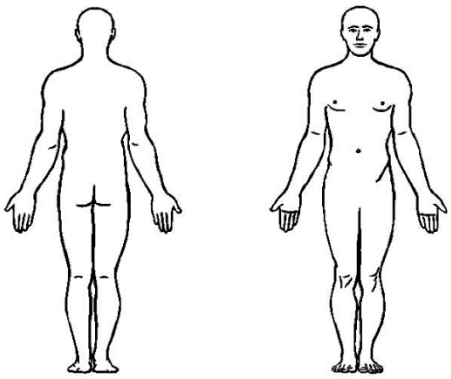
◯ **Progress evaluation** – I've been actively treating, and this is a periodic reevaluation.

◯ **New condition** – I've been actively treating and a new or returning condition has developed.

◯ **Returning patient** – I have not been seen in some time and a new or returning condition has developed.

Current Symptoms: _____

1. Location Circle the area(s) on the illustration where it hurts.



2. Type of symptoms
What kind of pain does it feel like?

☐ Numbness ☐ Aching ☐ Burning

☐ Tingling ☐ Cramps ☐ Shooting

☐ Stiffness ☐ Nagging ☐ Throbbing

☐ Dull ☐ Sharp ☐ Stabbing

☐ Other

3. Intensity (Rate your pain when it is at its worst)

0 ◯-◯-◯-◯-◯-◯-◯-◯-◯-◯ **10**

Absent Uncomfortable Agonizing

4. Duration and Timing
(In conjunction to the pain you rated in question 3: When did it start and how often do you feel it?)

◯ Constant ◯ Comes and goes

When did it start? _____

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?

_____

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

Worsens pain: _____

Lessens pain: _____

7. Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription Medication ☐ Surgery

☐ Over-the-counter Drugs ☐ Acupuncture

☐ Homeopathic Remedies ☐ Chiropractic

☐ Physical Therapy ☐ Massage

☐ Ice ☐ Other _____

☐ Heat

8. What else should Dr. Kanady know about your current condition? _____

_____

_____

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9. Review of systems (Identify any changes since your most recent evaluation with us)

	Worse	No change	Improved
a. **Musculoskeletal System** – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	○	○	○
b. **Neurological System** - Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	○	○	○
c. **Cardiovascular System** – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	○	○	○
d. **Respiratory System** – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	○	○	○
e**. Digestive System** – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	○	○	○
f. **Sensory System** – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	○	○	○
g. **Skin System** – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	○	○	○
h. **Endocrine System** – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	○	○	○
i. **Genitourinary System** – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	○	○	○
j. **Constitutional System** – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	○	○	○

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us:

_____

_____

11. Medications (please list all prescription and over-the-counter)

_____

_____

12. Social History (Tell Dr. Kanady about your health habits)

Alcohol use	○ Daily	○ Weekly	How much? _____
Coffee use	○ Daily	○ Weekly	How much? _____
Tobacco use	○ Daily	○ Weekly	How much? _____
Exercising	○ Daily	○ Weekly	How much? _____
Pain relievers	○ Daily	○ Weekly	How much? _____
Soft drinks	○ Daily	○ Weekly	How much? _____
Water intake	○ Daily	○ Weekly	How much? _____

Hobbies: _____

To the best of my ability, the information I have provided is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

_____ _____

Signature Date

Doctor notes:

Patient name: _____

Doctor's initials: _____

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