Update Health Information

General Information

Name: _____

Address: _____

City/State/Zip:_____

Telephone (Home):_____

Telephone (Cell):_____

Email Address: _____

Number of Children:_____

Occupation:_____

Employer:_____

Marital Status: Married Single

Spouse's Name:_____

Emergency Contact:_____

Phone:_____

Current Complaints

Please Describe:_____

_____

_____

Date Symptoms Appeared:_____

Nature of Injury

☐ Automobile ☐ Work ☐ Other

Please Describe:_____

_____

Date of Injury:_____

Have you ever had same condition?

○ No

○ Yes

If yes, when?_____

For Office Use Only
Acct #:_____
Patient Height_____
Patient Weight_____
Respiration _____
Patient Blood Pressure _____
Pulse_____
Temperature _____

Do you smoke? (circle) Yes No

Females Only: Are you or is there a possibility that you could be pregnant? (circle) Yes No

Do you have any allergies to medication? Yes No

If Yes, please indicate the following:

Allergy: _____

Allergy: _____

Are you taking any medications or supplements? Yes No

If Yes, please list below:

Medications: _____

_____

_____

_____

_____

Patient Signature:

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature/Guardian: _____

Date: _____