UPDATE

In order for us to best serve you, we must have all available information regarding your present health. To bring our original case history and our files up to date, would you please provide us with the following information?

Name: _____ Date: _____

☐ **Check here if all of the information below has not changed since your last visit to the clinic, or only what I have corrected has changed.**

Address: _____City: _____ State: _____ Zip _____
Telephone number (Home): _____(Cell)_____ (work): _____
Social Security #: _____
Race:____African American ___Asian ____Native American ____Pac. Islander ____White____ Declined to state
Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____ Declined to state
Your Occupation/Employer: _____
Spouses Name and Occupation: _____

1. Location of pain or pains: _____
2. What caused the pain(s)? _____
3. What does the pain feel like (ache, sharp, burn, ect)?_____
4. Where does the pain radiate? _____
5. How bad is the Pain on a 0-10 scale (0 = no pain; 10 = suicidal pain)? _____
6. Is the pain: __Constant 100%? __Frequent 75%? __ Intermittent 50%? __ Occasional 25%
7. What makes the pain worse? _____
8. What makes the pain better? _____
9. Recent surgery? Type and date: _____
10. Recent car crash? YES NO If yes, when? _____,
    What happened? _____
11. Recent Injury? Type and date: _____
12. Do you have insurance? ___ YES ___NO if yes, what company? _____
13. "Since I last saw you, I have been to see Dr_____
    for_____."

Smoking Status (circle only one)

Current smoker Smoking start date: _____ End date: _____
Current some day smoker
Former smoker
Never smoker

In an effort to quit smoking,
I am currently taking: _____

Do you have any allergies to medication? Yes No
If yes please indicate the following:

Allergy: _____
Reaction: _____
Start date: _____
End date: _____

Allergy: _____
Reaction: _____
Start date: _____
End date: _____

Allergy: _____
Reaction: _____
Start date: _____
End date: _____

Allergy: _____
Reaction: _____
Start date: _____
End date: _____

Are you currently taking any new medication since your last visit? Yes No
If yes, please indicate the following:

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Start date: _____
End date: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Start date: _____
End date: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Start date: _____
End date: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Start date: _____
End date: _____

Patient Signature: _____ 08/14

DOCTORS USE ONLY_____