Heresco
CHIROPRACTIC
massage • strength rehab

Today's Date: ____/____/____

Patient History Update

Patient Name: ____ What you preferred to be called?: _________________
First Last MI

Birthdate: ____/____/____ Age: ___ ❑Male ❑Female E-Mail Address: _____________________________________

Physical Address: ______________________________________ City, State, Zip: ________________________________

Cell Phone #: ___________________ Work Phone #: __________________ Home Phone # _______________________

For your appointment confirmations: (please choose one option)
❑Phone Call (*choose one*) ❑Email ❑Text Message (cell phone number required)
❑Home ❑Work ❑Cell

Status: ❑Minor ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed Spouse's Name:________________________

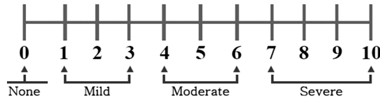
Do you have children? ❑No ❑Yes How Many: ________ *****Give Insurance Card to the Front Desk to be Scanned *****

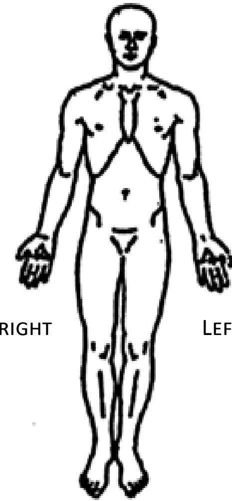
Employer: ___________________________ Employer's Address: ____

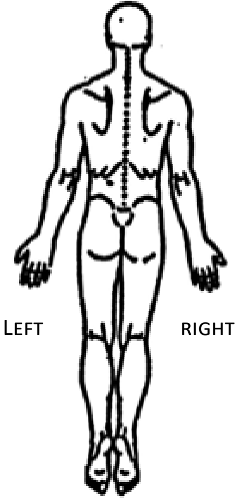
What is your Height ___________ Weight ___________ Occupation: ____

1. Please mark area(s) of injury or discomfort using
A) Letters to describe your pain
B) Numbers for the degree of pain using a scale from 1-10.

- N = Numbing
- P = Pins & Needles
- B = Burning
- A = Aching
- S = Stabbing







2. What are you present symptoms ____________________________________

3. How long have you had this problem?_________________________________

4. How do you think your problem began?_______________________________

5. What aggravates your condition? ___________________________________

6. What do you do to help alleviate your pain? ____

7. Please list any medications you are taking (or we can copy a list):
____

8. How often do you experience your symptoms?
75-100% ❑Constantly 50-75% ❑Frequently 25-50% ❑Occasionally 0-25% ❑Intermittently

9. Have there been any recent changes in your health?___________________________________

10. Recent falls, slips, or accidents:____

11. Recent surgery: ____

12. Date of your last physical:____

13. Since we last saw you, I have been seen by Dr. ______________________________________

Patient Signature____ **Date:** ______________

IN THE EVENT OF

Who should we contact?

____

Phone: ______________________

Other #: _____________________

FOR OFFICE USE ONLY

Pt file #: ____________________

BP: _________________________

Pulse: _______________________

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