

Confidential Medical History Update

Name: _____ Date of Birth ____/____/____ SS#: _____

Has any demographic or insurance information changed since your last course of treatment at our facility? Y__ N__

If yes, please indicate any changes below:

Address: _____ City/State/Zip: _____

Phone: _____ Cell: _____ Marital Status (Circle): M S D W

Occupation: _____ Are you presently working? Y__ N__

Employer: _____ Employer Phone: _____

Insurance Company: _____ ID#: _____

Name of Card Holder: _____ Date of Birth ____/____/____ SS#: _____

Have you received any of the following services during your current insurance plan year?

Occupational Therapy	Y__ N__	Massage Therapy	Y__ N__
Physical Therapy	Y__ N__	Chiropractic Services	Y__ N__
Speech Therapy	Y__ N__	Home Health Services	Y__ N__

Have you had any changes in your medical history since your last course of treatment at our facility? Y__ N__

If yes, please indicate any changes below:

Referring Physician: _____ Referral Date: _____

Chief Complaint: _____ Date of Injury: _____

Current Symptoms: Pain Numbness Stiffness Weakness Other: _____

List all medications you are currently taking: _____

None

List any known allergies: _____

None

List any previous surgeries: _____

None

Have you had any diagnostic imaging for this injury? MRI XRAYs CT SCAN Other: _____

None

Do you smoke? Y__ N__ How much/often? _____

Do you consume alcohol? Y__ N__ How much/often? _____

Do you exercise regularly? Y__ N__ How much/often? _____