

PREMIER REHAB

Information Update

Please update any information that has changed since your last visit to our office.

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Home Phone _____

Employer _____ Work Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Email Address _____ Cell Phone _____

Family Physician _____ Date of last physical _____

Preferred Language English Other Race: White African American Other

Current condition information

When did your condition begin? _____

Is your condition due to an Automobile Accident? Yes No

Is your condition due to an Employment Related Injury? Yes No If so, have you reported it? Yes No

Day lost from work _____ Other Doctors seen for this condition _____

Have you had the same or similar symptoms before? Yes No Approx. Date of prior condition _____

May we forward our findings to your family physician? Yes No

Mark Areas of Pain on Figures Below

List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Have you had chiropractic care before? Yes No

Family Physician _____

May we forward our findings to your doctor? Yes No

Current Medications _____

Allergies (Medicine, Food, Environment) _____

Previous Surgeries _____

Do you have a PERSONAL history of: Cancer Diabetes Heart Disease Stroke

Other serious illnesses _____

Check all symptoms that apply to you:

- | | | | |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Tingling/numbness in arms/hands | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Tingling/numbness in legs/toes | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Loss of balance/dizziness | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fever | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Pain unrelieved by rest |

For women: Are you pregnant? Yes No

Are you taking birth control? Yes No