DR. DAN
CHIROPRACTIC & MASSAGE

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Patient Condition Update Form:

Date _____/_____/_____ ☐ Male ☐ Female

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City/State/Zip: _____

Cell Phone: (_____) _____-_____ Cell Carrier: _____ Email: _____

How do you wish to pay for your Chiropractic care?

☐ Auto ☐ L&I Claim #:_____ Your Auto Insurance _____

Claims Adjustor: _____ Adjustor's Number: (_____) _____-_____

☐ Cash, Check or Charge

☐ Health Insurance……Same since last visit ☐ Yes ☐ No If no, please fill out information below

Name of Insurance Company: _____ ID #: _____

Policy Holder: _____Holder's Date of Birth: _____/_____/_____

Primary health concern(s): _____

_____

_____

How did it start? _____ When did it start? _____

Rate pain (circle one, 10 = severe): 1 2 3 4 5 6 7 8 9 10 Does it radiate anywhere? ☐ Yes ☐ No

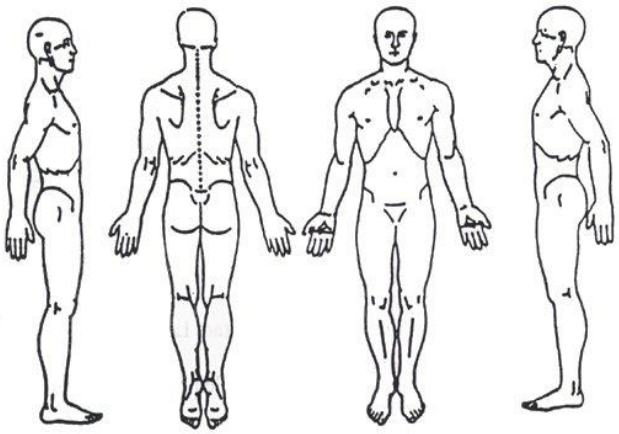
What helps it feel better? _____ What makes it feel worse? _____

It bothers me: ☐ Constantly ☐ Intermittently ☐ Morning ☐ Evening ☐ Work ☐ Other _____

Whom else have you seen for this condition? _____

☐ Achy	☐ Tight
☐ Sore	☐ Stiff
☐ Sharp	☐ Dull
☐ Radiating	☐ Burning
☐ Stabbing	☐ Shooting
☐ Pins & Needles	☐ Numbness

Mark all that apply:



Please indicate areas of pain in diagram above

☐ I have previously signed the consent to x-ray and HIPPA privacy agreements on my initial visit to the office.

Signature: _____ Date: _____