



PATIENT UPDATE

Please take the time to complete these forms to the best of your ability. If you have any questions, we will be glad to help you.

First Name _____ **Middle Initial** _____ **Last Name** _____

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (if different) _____

City _____ State _____ Zip Code _____

Email Address* _____

Cell Phone _____

Would you like to receive text reminders? Yes No

Home Phone _____

Work Phone _____

Emergency Contact Name _____

Phone # _____

Primary Care Physician _____

Phone # _____

Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____

Employment Status: Employed _____ Not Employed Retired Student
(employer name)

Marital Status: Single Married Divorced Widowed

COVERAGE INFORMATION

If you are **Self Pay**, please request a copy of our updated fee schedule. If you are **Insured**, please provide your insurance card(s) to reception with your Identification Card. Digital cards should be emailed to thebackalleychiro@yahoo.com.

Self Pay Health Insurance Medicare/Medicaid

SYMPTOMS

List and describe your **chief complaint** and answer all questions following. If you need more space, please ask for an additional page.

Chief complaint _____ How long ago? # _____ Days # _____ Weeks # _____ Months # _____ Years

How did this begin? job related injury auto accident illness injury unknown gradual onset sudden onset

Severity: 0 1 2 3 4 5 6 7 8 9 10 Intensity: light moderate extreme

Timing: seldom repeatedly frequently constant How often of the day? 0-25% 25-50%

50-75% 75-100% in the morning in the afternoon in the evening the full day

Condition is: **Aggravated** by _____ **Improved** by _____

To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, or emails as an extension of my care in this office. *Providing an email is explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details)

Patient or Parent/Guardian Signature _____ Date _____