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

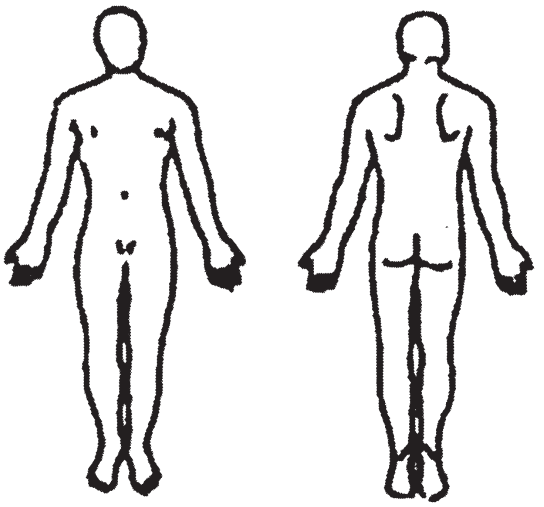
Is your condition due to an Employment Related Injury? ☐ Yes ☐ No If so, have you reported it? ☐ Yes ☐ No

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:

☐ Headache	☐ Tingling/numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Other _____		☐ Night Pain	☐ Pain unrelieved by rest

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No