IMBROGNO CHIROPRACTIC & HEALING ARTS CENTER 973-783-0444

PATIENT INFORMATION UPDATE

IN ORDER TO BRING YOUR CASE HISTORY UP TO DATE, WE MUST HAVE CURRENT INFORMATION REGARDING YOUR PRESENT HEALTH. PLEASE COMPLETE THE FOLLOWING, EVEN IF YOU THINK WE HAVE THE INFORMATION:

Name: _____ Age: _____ Date of birth: _____

Parent/Guardian Name (If Patient is a minor): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home _____ Cell _____ Work _____

E-mail: _____

Emergency contact: _____
(Name, phone and relationship to you)

Purpose of this appointment: _____

When did this condition begin? _____ Is it getting better, worse or the same? (please circle)

Do you experience: aching, numbness, pain, spasm, stabbing, stiffness, tingling, weakness, other_____?

% of time you experience symptoms: _____ Rate your pain: mild 1 2 3 4 moderate 5 6 7 8 severe 9 10 10+ (circle)

Do your symptoms radiate / refer to any other part of your body? _____

Does this condition interfere with your: daily routine / sleep / work / exercise / sports / child-elder care / other? (circle ALL that apply)

What helps your condition? _____ What makes it worse? _____

Have you seen any other chiropractor / medical doctor / other health care practitioner since your last visit? Yes No (circle)

If yes, whom did you see? _____ Are you still under care? _____ Date of last treatment? _____

Have you had acupuncture, massage or other forms of bodywork? _____

Do you exercise regularly? _____ What form of exercise? _____

What do you do for stress reduction? _____

How long has it been since you really felt good? _____

List ALL medications, vitamins, herbs or homeopathics you are taking: (use the back if necessary)

_____

List ANY hospitalizations, surgical procedures falls, accidents, and injuries since your last visit: (use the back if necessary)

_____

Have you been diagnosed or treated for any other medical conditions since your last visit here? Yes No (circle)

If yes, please explain: _____

CONSENT FOR PROFESSIONAL SERVICES
I hereby authorize the doctor(s) to administer chiropractic examination, chiropractic care, treatment, order x-rays or imaging studies or any other services that she deems necessary in my (or my child's) case.

Patient (Parent/Guardian) signature _____ Date _____