CALEDONIA CHIROPRACTIC CLINIC

5401 Douglas Ave., Suite A,
Racine, WI 53402
Phone: 262.681.8829

CURRENT PATIENT UPDATE FORM

Name: ________________________________ DOB: ______________
Address: ________________________________
City: ____________________ State: __________ Zip Code: __________
Primary Phone: ______________ C / H / W Alternate Phone: ______________ C / H / W
E-mail: ________________________________
Employer: ____________________ Phone#: ______________
Is your injury due to an automobile accident? □ No □ Yes or a work related incident? □ No □ Yes
List ***ALL*** of your current complaints, ***DO NOT*** leave these blank:
1) ______________________ Pain 0-10: _______ Date it started: _________
2) ______________________ Pain 0-10: _______ Date it started: _________
3) ______________________ Pain 0-10: _______ Date it started: _________

The overall frequency of your complaints is: ❑ Occasiona ❑ Intermittent ❑ Frequent ❑Constant

If your complaints include pain, how would you describe it? (Please check all that apply)

❑ Aching ❑ Burning ❑ Dull ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing
❑ Other:________________________________

If your symptoms change, are they worse in the: ❑ Morning ❑ Evening ❑ Night ❑ N/A

Do work activities aggravate your present complaints? ❑ Yes ❑ No ❑ N/A

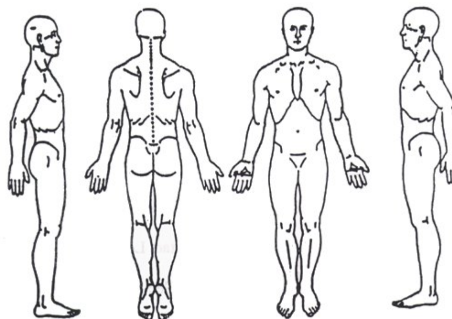
How often does your job involve lifting? ❑ Never ❑ Occasionally ❑Frequently ❑ Constantly

Other job requirements (please check all that apply): ❑ Bending ❑ Carrying ❑ Stooping
❑ Twisting ❑ Turning ❑ Walking ❑Other:________________________

What is your primary work position? ❑ Seated ❑ Standing ❑ Other: ______________

Please select one:

- **Progress Evaluation:** I have been under active care and this is a periodic reevaluation.
- **New Condition:** I have been under care and a new or returning condition has emerged.
- **Returning Patient:** After a period of inactivity, I have had a relapse or a new health issue.



On the pictures, please mark where it hurts:

O = for current condition.

X = for condition experienced in the past.

Have you had problems in the past with these symptoms/pain? ❑ No ❑ Yes

If Yes, who have you seen for these complaints and when ?

Name:________________________________ Date: ______________

Name:________________________________ Date: ______________

Name:________________________________ Date: ______________

REVIEW OF SYSTEMS: (Type in if a symptoms have gotten **WORSE**, there's been **NO CHANGE** or has **IMPROVED**)

1. **Musculoskeletal System:** (osteoarthritis, arthritis, neck/back pain, poor posture, etc) ____________
2. **Neurological System:** (anxiety, depression, headache, dizziness, pins & needles, numbness etc.) ____________
3. **Cardiovascular System:** (high or low blood pressure, high cholesterol, angina, etc.) ____________
4. **Respiratory System:** (asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia etc.) ____________
5. **Digestive System:** (anorexia/bulimia, ulcers, food sensitivities, heartburn, constipation, diarrhea, etc.) ____________
6. **Sensory System:** (blurred vision, ringing in ears, hearing loss, chronic ear infections, etc.) ____________
7. **Skin System:** (skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.) ____________
8. **Endocrine System:** (thyroid issues, immune disorder, hypoglycemia, frequent infection, etc.) ____________
9. **Genitourinary System:** (kidney stones, infertility, bed wetting, prostate issues, PMS symptoms, etc.) ____________
10. **Constitutional System:** (fainting, low libido, poor appetite, fatigue, weakness, fevers, chills etc.) ____________
11. **Hematologic/Lymphatic:** (anemia, swelling, lymphoma, etc.) ____________
12. **Allergies:** (sneezing, itchy eyes, etc.) ____________
13. **Psychological:** (anxiety, depression, anger issues, etc.) ____________

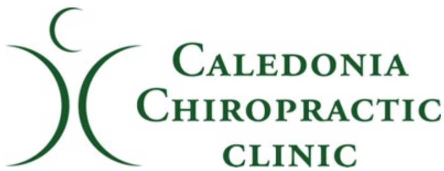
Difficulties with Activities of Daily Living (check all that apply)

Activity	None	Mild	Moderate	Severe	Activity	None	Mild	Moderate	Severe
Sitting	❑	❑	❑	❑	Grocery shopping	❑	❑	❑	❑
Rising out of a chair	❑	❑	❑	❑	Showering or Bathing	❑	❑	❑	❑
Standing	❑	❑	❑	❑	Lifting Objects	❑	❑	❑	❑
Walking	❑	❑	❑	❑	Reaching Overhead	❑	❑	❑	❑
Lying Down	❑	❑	❑	❑	Caring For Family	❑	❑	❑	❑
Bending Over	❑	❑	❑	❑	Dressing Myself	❑	❑	❑	❑
Climbing Stairs	❑	❑	❑	❑	Love of Life	❑	❑	❑	❑
Computer Use	❑	❑	❑	❑	Getting To Sleep	❑	❑	❑	❑
Exercising	❑	❑	❑	❑	Staying Asleep	❑	❑	❑	❑
Driving A Car	❑	❑	❑	❑	Concentrating	❑	❑	❑	❑
Getting out of a car	❑	❑	❑	❑	Yard Work Shoveling/Raking	❑	❑	❑	❑
Looking over shoulder	❑	❑	❑	❑	Household Chores	❑	❑	❑	❑
Other	❑	❑	❑	❑	Other	❑	❑	❑	❑

I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and direct my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office. I agree to examination and chiropractic treatment as outlined by the doctor. I understand I may be billed directly for any missed appointments.

______________________________ ______________________ ______________

Patient or Responsible Party Signature | Relationship to Patient | Date



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PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Caledonia Chiropractic Clinic to serve the healthcare needs of you and your family. We are pleased to participate in your healthcare and look forward to establishing a lasting relationship as your healthcare provider. As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Policy. Please read this document thoroughly.

ADDRESS CHANGE: It is important that we have your correct address on file. Please advise us any time there is any change to your address, telephone number or other contact information.

INSURANCE: Your insurance contract is between you, your employer and/or the insurance company. Not all services are covered by all contracts. Any questions or complaints regarding your coverage should be directed to your insurance carrier.

INDIVIDUAL FINANCIAL RESPONSIBILITY:

- I understand that I am financially responsible for my health insurance deductible, coinsurance, and non-covered services.
- If I fail to provide current and correct insurance information, I will be responsible for payment of all services provided.
- I understand that Co-pays are due at the time of service.
- I understand that if I am Self-pay, payment in full is due at the time of service.
- In the event that my health plan determines a service to be ‘non-payable’, I will be responsible for the complete charge and agree to pay the cost of all services provided.

INSURANCE AUTHORIZATION FOR ASSESSMENT OF BENEFITS: I hereby authorize and direct payment of my medical benefits to Caledonia Chiropractic Clinic on my behalf for any services furnished to me by the provider.

AUTHORIZATION TO RELEASE RECORDS: I hereby authorize Caledonia Chiropractic Clinic to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me, needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

SCHEDULED APPOINTMENTS WITH THE MASSAGE THERAPIST AND THE CHIROPRACTOR: I understand that a 24-hour notice is required for cancellation of an appointment and should I fail to do such, the fee of the total amount of the appointment may be charged to me. This fee must be paid prior to any additional appointments.

PERSONAL INJURY AND WORKMAN’S COMPENSATION CLAIMS: I understand that if my medical condition involves a personal injury or workman’s compensation case, I will notify the provider/staff before my scheduled appointment. All additional documentation will be completed at the time of service. Any additional documentation requested by the provider/staff will be presented within 7 days. Should my claim be denied, I understand I am responsible for all medical charges, either after submission to my insurance or in full if I have no insurance.

EFFECTIVE DATE: *Once you have signed this agreement, you agree to all the terms and conditions herein and the agreement will be in force and effect.*

________________________________ ________________________

Print Patient Name or Responsible Party | Date

________________________________ ________________________

Patient or Responsible Party Signature | Relationship to Patient