Returning Patient Health Update

Instructions: *Complete this form if you are a patient at our office but have not been seen/treated in more than 30 days.*

Patient Information:

Name: ____ Date of Birth: __________________________

Address: ____

Email Address: ____ Cell Phone: ____________________________________

How would you like for us to send appointment reminders? □Email □Text □Call □I don't need reminders.

Emergency Contact Name	Relationship to Patient	Phone

Primary Health Insurance

New Health Insurance Company: ____

Member Number: ____Group Number: ____________________________

Your Complaints: Reason for Today's Visit

What brings you into the office today (what's hurting? Or what's bothering you?)							
□Headaches	□Jaw Pain	□Neck Pain	□Mid Back Pain	□Upper Back Pain	□Lower Back Pain	□Pelvic Pain	□Finger Pain
□Hip Pain	□Thigh Pain	□Knee Pain	□Lower Leg Pain	□Ankle Pain	□Ankle Pain	□Foot Pain	□Toe Pain
How long have you experience the above issues?							
□Just started	□A few days (less than 5 days)	□About a week	□Months	□Years (less than 3 years)	□Varies		
What have you done to treat or manage the above issues? (check all that apply)							
□Saw a medical doctor	□Saw an orthopedist	□Saw a podiatrist	□Had x-rays	□Had an MRI	□Had a CT Scan		
□Had an Ultrasound	□Had Physical Therapy	□Saw another Chiropractor	□Over-the-counter medication (s)				
□Prescribed medication(s)	□Stretched	□Exercised	□Used Ice Packs	□Used Heating Pad	□Rest		
□I haven't done anything.							

Patient Medical Questionnaire

Primary Medical Physician Name	Phone Number	Fax Number

When was your last visit to your primary medical physician (medical doctor)? ______________________________

Have you been diagnosed with any new health conditions since the last time you were seen in this office? □Yes □No. If *"yes" please put the health condition in the space below.*

Have you had any of the following health occurrences, accidents, or injuries since the last time you were seen in this office?

Auto Accident	□Yes □No	Significant Fall	□Yes □No
Heart Attack	□Yes □No	Seizure(s)	□Yes □No
Head Injury	□Yes □No	Concussion(s)	□Yes □No
Work Injury	□Yes □No	Cancer	□Yes □No

Have you been hospitalized (for any reason) since the last time you were seen in this office? *If "yes", please list when you were hospitalized in the space below.*

Date of Birth:

Patient Name:

Harmonious Living Chiropractic: Fitness & Wellness Center, LLC
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Have you had a new surgical procedure (for any reason) since the last time you were seen in this office? *If "yes", please list the surgical procedures in the space below.*

Review of Medical History and Bodily Systems: Circle if you have or had any of the following health conditions.

Abnormal bleeding disorder Acid reflux (GERD) Anemia Anemia Angina/chest pain Anti-coagulant therapy Anxiety Arthritis Asthma Auto immune disease Balance issues Bipolar Bladder infection Blood (black) stools Blood clots Bone fracture Brittle bones Bronchitis Childbirth Concussion Congestive heart failure Constipation COPD Deep vein thrombosis	Defibrillator Depression Diabetes Dialysis Difficulty hearing Difficulty swallowing Dizziness Double vision Eczema Enlarged lymph nodes Enlarged prostate Erectile dysfunction Gout Head injury Hearing loss Heart disease Heart murmur or valve issue Heart stint Heart surgery Hematuria (blood in urine) Hemophilia Hodgkin's lymphoma Hormone replacement therapy Hypertension (high blood pressure)	Hypotension (low blood pressure) Injectable steroid replacement Irritable bowel syndrome (IBS) Joint dislocation Kidney disease Kidney failure Kidney stones Loss of smell Loss of taste Loss of vision Lupus Lymphedema Memory loss Metal implants/rods Miscarriage Nausea Osteoarthritis Osteopenia Osteoporosis Pacemaker Pancreatic disease Pregnancy (past) Pregnant (currently) Psoriasis	Psychiatric disorder PTSD Rheumatoid arthritis (RA) Schizophrenia Scoliosis Shortness of breath Significant burns Skin grafts Spinal fracture Spinal surgery Thyroid disease Tuberculosis Use a hearing aid Uterine fibroids Vertigo Visual changes Vomiting Vomiting blood Wear glasses or contacts Wheezing

List any medications you are currently taking, including prescription and over-the-counter medications.

Do you have any health concerns the doctor should be aware of? □Yes □No *If "yes", please provide the health concern in the space below.*

Printed Name of Patient/Legal Guardian ______ Signature of Patient/Legal Guardian ______ Date ______

DO NOT WRITE IN THIS AREA – DO NOT WRITE BELOW THIS AREA – DO NOT WRITE BELOW THIS AREA – Clinical Use

Date Received: ________________ Date Reviewed by Doctor: ________________

Doctor Printed Name: ________________ Doctor Signature: ________________

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