FOX
Chiropractic Center

History Update

Name:_____ Birthdate: _____ Date:_____

Address:_____City: _____State: _____ Zip:_____

Cell Phone:_____Phone Carrier, AT&T, T-Mobile,Verizon, other_____

E-Mail:_____

Emergency Contact: _____ Relationship: _____ Cellphone: _____

Updated Health History (Recent accidents, hospitalizations, or illnesses since your last visit):

_____

_____

List of Current Medications

_____

_____

_____

Describe your current problem _____

When did the symptoms start_____

Described pain/discomfort (CIRCLE) ACHING, BURNING, SHARP, SORE,TIGHT, STABBING, STIFF

Is pain/discomfort primarily on one side (Circle) Right /Left /Bilateral

Have you seen anyone else for this condition_____, If so who? _____

Do you have spinal X-Rays, MRI, CT SCAN?_____

On a Scale of 1 to 10, with 10 the most intense discomfort, how would you rate your discomfort?

1 2 3 4 5 6 7 8 9 10

Good Bad

I certify that I have read the above information. I understand that providing inaccurate or incomplete information can be dangerous to my health. I authorize Fox Chiropractic Center to release any information pertinent to care rendered to my child or myself during the period of chiropractic care to third party payer and or to health practitioners. I authorize and request my insurance co. to pay directly to Fox Chiropractic Center insurance benefits otherwise payable to myself. I understand that my insurance carrier may pay less than the actual bill and that I am responsible for payment for all services rendered on my behalf or my dependents.

Patient Signature:_____