

Working for your wellness, naturally

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UPDATE/RE-EXAM

NAME: _____ DATE: _____

BIRTH DATE: _____
LAST VISIT TO ADVANCED CHIROPRACTIC: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE: _____

WORK TELEPHONE: _____

E-Mail _____

INSURANCE COMPANY: _____

SOCIAL SECURITY NO.# _____

CHANGE IN STATUS: MARRIED SINGLE DIVORCED

REASON FOR TODAY'S VISIT: Please describe applicable.

_____ CHECK UP
_____ NEW HEALTH PROBLEM

ACCIDENT/INJURY: _____ AUTO _____ WORK _____ OTHER
DATE OF INJURY: _____

PLEASE DETAIL YOUR HEALTH CONCERNS/INJURY: _____

WHAT HAVE YOU DONE TO RESOLVE YOUR SYMPTOMS: _____

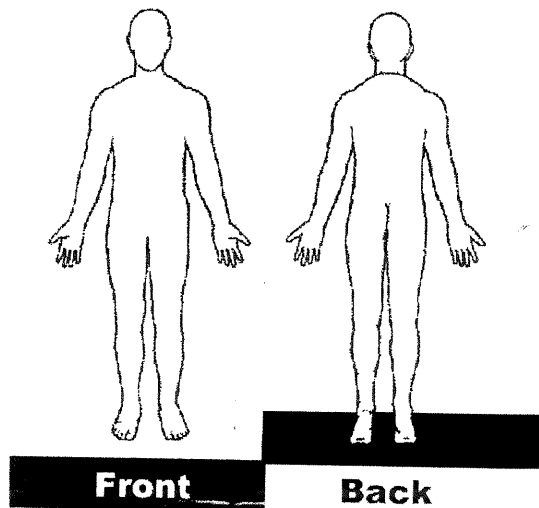
UPDATED MEDICAL HISTORY:
RECENT SURGERIES/MEDICAL PROCEDURES: _____

LAST DOCTOR VISIT/ADDRESS: _____

PLEASE FILL OUT REVERSE SIDE

On illustrations below, please draw a line from the area of pain or injury to the word which most accurately describes it.

Where /What Kind of Pain is It?



SHARP / DULL / TINGLING / NUMBNESS
OCCASSIONAL (_____ % of the Time) / CONSTANT /OTHER
NO PAIN (0 1 2 3 4 5 6 7 8 9 10) UNBEARABLE

IT IS WORSE WHEN: _____

IT IS BETTER WHEN: _____

OTHER COMMENTS: _____

SIGNED: _____ **DATE:** _____
PATIENT