

PATIENT UP-DATE

Please PRINT all of the following information. EVEN if the information is the same as last year. We need to verify that we have the correct and current information in our computer.

Name: _____ Home Phone Number: (____) _____
 Home Address: _____ City _____ State _____ Zip _____
 Mailing Address: _____ City _____ State _____ Zip _____
 E-Mail Address: _____ Cell Phone Number (____) _____
 Date of Birth: _____ Partner's Name: _____
 Employer's Name: _____ Work Phone Number: (____) _____
 Work Address: _____ City _____ State _____ Zip _____
 Employment Status: Full Time Part Time Retired
 In Case of Emergency please contact: _____ Phone Number (____) _____

Your primary complaints: _____

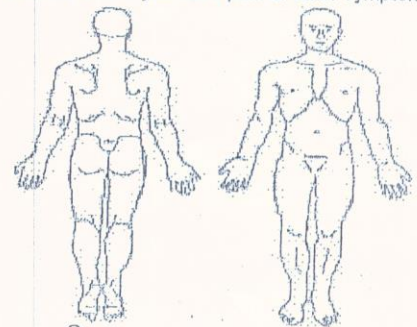
Is your current condition related to an accident? Yes No. If yes please complete the following:

Date of accident: _____ How did it occur? _____

Symptoms began on:

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Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____

Date: _____