

DURHAM CHIROPRACTIC

Patient Information Update

Dr Joel Durham, DC, CCSP
Certified Chiropractic Sports Physician

Name _____ Date _____
Address _____

Age _____ Contact Phones (Home) _____ (Work) _____ (Other) _____

Health Insurance? No Yes *Please present any new insurance cards to receptionist
Insured's Name (if different) _____ Date of Birth _____

Reason for today's visit? Maintenance Check-up New problem Old problem
caused by? Strain Fall Auto Accident On the Job Injury Unknown

Describe current problem & date of onset: _____

Rate the severity of pain 0 (no pain) up to 10 (extreme pain) _____

Is condition getting Better Worse No Change

Describe the discomfort Dull Ache Sharp Shooting Throbbing Cramps
 Stiffness Burning Tingling Numbness Swelling Other

How often do you have the symptoms? 75-100% 50-75% 25-50% <25% of the time

Any pain, tingling, numbness, or weakness radiating into the extremities? No Yes

What makes the symptoms worse? _____

What makes the symptoms better? _____

This problem interferes with my Daily Routine Work Sleep Recreation

Name other Doctors seen for this condition _____

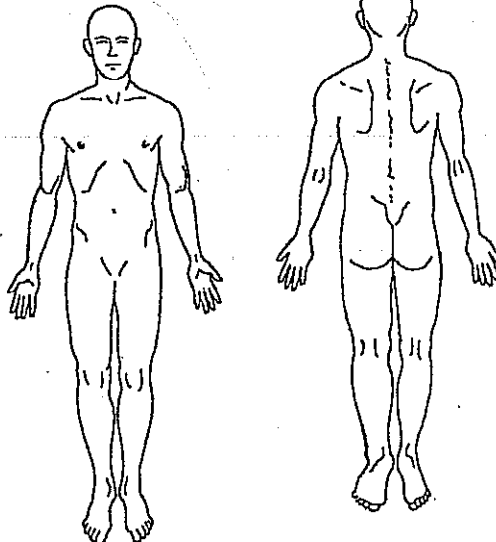
What treatments have been used? None Ice Heat Medications
 Physical Therapy Surgery Chiropractic

Any other injuries, problems, surgeries, or new medications since your last visit? No Yes
If yes, please explain _____

Have you seen a Chiropractor and/or Medical Doctor since your last visit? No Yes
If yes, please explain _____

Please list your Family Doctor _____

Please mark your problem areas on the figures below



Thanks for taking a moment to help us update your file!