Great Lakes Chiropractic

116 Central Ave East St. Michael, MN 55376
763-515-6650

PATIENT UPDATE FORM

NAME:____**DATE:**__________________

ADDRESS:____

PHONE: *(home_____ cell_____)* ____

Email: ____

Health Insurance Company: ____

POLICY NUMBER: ___________________________ **GROUP NUMBER:** ___________________________

COMPLAINT – What is the purpose of this appointment? _______________________________________

____

LOCATION – Where does it hurt? Left? Right? Both sides?____

QUALITY OF PAIN - How would you describe your problem? Please circle all that apply.

Sharp	Shooting	Burning	Numb	Tingly
Dull	Achy	Sharp with Motion	Shooting with Motion	Stabbing with Motion

Other:____

FREQUENCY OF PAIN - How often do you have this problem? Please check ✓

Constantly (75-100% of the time)	Frequently (50-75% of the time)	Occasionally (25-50% of the time)	Intermittently (less than 25% of the time)

SEVERITY – How would you rate the severity of your problem?

Mild	Moderate	Severe

RADIATING – Does your pain radiate anywhere in your body? If yes, please describe

____

NIGHT PAIN – Do you have pain at night? If yes, please describe

____

AGGRAVATING FACTORS - What makes your problem worse? Please circle all that apply.

Always there	Gardening	Shoveling	Standing up	Yard Work
Bending	Working Out	Sitting	Standing (long time)	Weather Changes
Driving	Lifting Objects	Sleeping	Stress	While at Work
Flexing/extending	Painting	Climbing Stairs	Computer Work	Sports:

Other, describe____

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RELIEVING FACTORS - What makes your problem better? Please circle all that apply.

Adjustments	Heat	Ibuprofen	Standing	Warm Bath
Bending Forward	Ice	Tylenol	Stretching	Nothing
Exercising	Massage	Rx Pain Medication	TENS/Muscle Stim	
Pain Relieving Cream	Muscle Relaxer	Resting	Walking	

Other ____

Who have you seen for this problem? Please circle all that apply.

Chiropractor	ER Doctor	Massage Therapist	Physical Therapist
Neurologist	Orthopedist	Primary Care Doctor	No One

When and Where? ____
Other____

How long have you had this problem? #_____Year(s) # _____Month(s) #_____Week(s) #_____Day(s)

MEDICATIONS/SUPPLEMENTS:
What medications are you taking? List dose/frequency
____

List any nutritional supplements you are taking (vitamins, herbs, naturopathic remedies, etc) _______________
____

Have you had surgery in the past 6-12 months?____
____

Have you had any injuries/trauma not already stated in the past 6-12 months?___________________________
____

Have you seen a medical doctor for anything in the past 6-12 months? **Yes** or **No**
If yes, describe: ____

Patient's Signature: ____ **Date:** _________________

Guardian's Signature Authorizing Care: ________________________________ **Date:** _________________

For Doctor's Use Only

CERVICAL	THORACIC	LUMBOSACRAL	M99.08 rib	M54.31 R sci ___
M99.01___	M99.02___	M99.03___ M99.04___	S23.41XA rib ___	M54.32 L sci ___
M54.2___ M62.830___	M54.6___ M62.830___	M54.5___ M62.830___	G44.201 HA ___	M54.41 P! w sci R___
S13.4XXA___	S23.3XXA___	S33.5XXA___	M43.6 tcollis ___	M54.42 P! w sci L___
Exam 2 3 4	Re-Exam 2 3 4	98940 ____ 98941 ____	97110______	97012 ____ 97014___

Dr Signature: ____ Date: ___________________

Last Updated on:5/25/2021