Great Lakes Chiropractic of St. Michael
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

PATIENT UPDATE FORM

______________________________ ______________
NAME DATE

____
STREET ADDRESS CITY STATE ZIP CODE

______________________ ______________________
PHONE NUMBER EMAIL

______________________ ______________________
EMERGENCY CONTACT NAME EMERGENCY CONTACT PHONE NUMBER

COMPLAINT – What is the purpose of this appointment? ______________________________

____

LOCATION – Where does it hurt? ☐ Left ☐ Right ☐ Both

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

SYMPTOM	PAST	PRESENT	
Headache			L☐ | R☐
Neck pain			L☐ | R☐
Upper back pain			L☐ | R☐
Mid back pain			L☐ | R☐
Low back pain			L☐ | R☐
Shoulder pain			L☐ | R☐
Elbow			L☐ | R☐

SYMPTOM	PAST	PRESENT	
Foot pain			L☐ | R☐
Wrist pain			L☐ | R☐
Hip pain			L☐ | R☐
Upper leg pain			L☐ | R☐
Knee pain			L☐ | R☐
Ankle pain			L☐ | R☐
Jaw pain			L☐ | R☐

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?

☐ 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.

____

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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____

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? ____

Females: Are you pregnant? Y / N. If yes, due date: ________________________

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___	M62.830___ M54.6___	M62.830___ M54.50___	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: ____________________