File Update
Form A2

File #________

Name: ______________________ Date: ______________

Address: ______________________ Town: ______________

PO Box _______ 911 #_________ Apt. # _________ Postal Code ______________

Home Phone #: ______________________ Work Phone #: ______________

Occupation ______________________

What problem(s) would you like the doctor to address? ______________________

Explain how your complaint(s) occurred: ☐ No Reason ☐ At Work ☐ Car Accident

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Is your condition... ☐ Worse ☐ Better ☐ Same ☐ Fluctuates

What makes your condition worse? ______________ better? ______________

Are you taking medications for this problem? ☐ No ☐ Yes (list) ______________

Since my last visit to this office...

New Medications:

☐ Pain Killers ☐ Muscle Relaxants ☐ Arthritis Meds. ☐Nerve Pills ☐ Blood Pressure Pills ☐ Insulin

☐ Heart Meds. ☐ Birth Control ☐ Estrogen ☐ Vitamins ☐ Blood Thinners ☐ Thyroid Pills

☐ Other (please list) ______________________

Surgeries: ☐ Back ☐ Neck ☐ Joint Replacement ☐ Gall Bladder ☐ Appendix ☐ Tonsils ☐ Hernia ☐ Heart ☐ Other

Significant Injuries (Broken bones, sprains, falls): ______________________

Serious Illnesses/ Hospitalizations: ______________________

X-Rays: ______________________

Pregnant: ☐ No ☐ Yes