PREMIER REHAB

Information Update

Please update any information that has changed since your last visit to our office.

Address	Name		Date			
Emergency Contact	Address	City		State	Zip	
Emergency Contact	Occupation		_Home Phone			
Email Address	Employer					
Preferred Language English Other Race: White African American Other Current condition information When did your condition begin? Is your condition begin? Is your condition due to an Automobile Accident? Yes No Is your condition due to an Employment Related Injury? Yes No If so, have you reported it? Yes No Day lost from work Other Doctors seen for this condition Have you had the same or similar symptoms before? Yes No Approx. Date of prior condition May we forward our findings to your family physician? Yes No Mark Areas of Pain on Figures Below List chief symptoms in order of severity: (1)	Emergency Contact	Relationship	P	hone		
Preferred Language English Other Race: White African American Other Current condition information When did your condition begin? Is your condition due to an Automobile Accident? Yes No Is your condition due to an Employment Related Injury? Yes No If so, have you reported it? Yes No Day lost from work Other Doctors seen for this condition Have you had the same or similar symptoms before? Yes No Approx. Date of prior condition May we forward our findings to your family physician? Yes No Approx. Date of prior condition Is stated from the same or similar symptoms before? Yes No Approx. Date of prior condition Is stated from the same or similar symptoms in order of severity: (1)	Email Address	Cell Phor	ne			
Current condition information When did your condition begin? Is your condition due to an Automobile Accident?	Family Physician	Date of last physic	al			
When did your condition begin? Is your condition due to an Automobile Accident?	Preferred Language ☐ English ☐ O	other Race: White Africa	can American 🛮 Oth	er		
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May we forward our findings to your family physician?						
Mark Areas of Pain on Figures Below List chief symptoms in order of severity: (1)		•				
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Have you had chiropractic care before? Yes No Family Physician May we forward our findings to your doctor? Yes No Current Medications Allergies (Medicine, Food, Environment) Allergies (Medicine, Food, Environment) Previous Surgeries Do you have a PERSONAL history of: Cancer Diabetes Heart Disease Stroke Stroke Other serious illnesses Check all symptoms that apply to you: Headache Tingling/numbness in arms/hands Chest Pain Unexplained weight lo Neck Pain/Stiffness Tingling/numbness in legs/toes Knee Pain Fatigue Back Pain/Stiffness Loss of balance/dizziness Hip Pain Night Sweats Shoulder Pain Shortness of breath Fever Blood in Urine	Ω					
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□ Other	☐ Shoulder Pain ☐ Shortness of breath		-	•		
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For women: Are you pregnant? \(\subseteq \text{ Yes} \subseteq \text{ No} \) Are you taking birth control? \(\subseteq \text{ Yes} \subseteq \text{ No} \)			u taking hirth control	9 □ Vec □	ΠNo	