

ADULT MEMBER HEALTH RECORD UPDATE

INFORMATION UPDATE

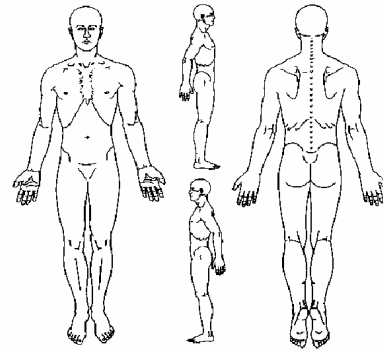
PERSONAL INFORMATION		
NAME:		DATE:
CHANGE OF ADDRESS:	CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:	
WORK PHONE:	EMAIL ADDRESS:	
HAS YOUR INSURANCE CHANGED SINCE YOUR LAST VISIT? (IF YES, PLEASE PRESENT YOUR NEW INSURANCE CARD TO THE FRONT DESK) <input type="checkbox"/> YES <input type="checkbox"/> NO		
EMPLOYER INFORMATION		
CHANGE OF EMPLOYER NAME:		
EMPLOYER ADDRESS:	EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:
POSITION/TITLE:		

YOUR CURRENT HEALTH STATUS

IS THIS A: <input type="checkbox"/> NEW INJURY <input type="checkbox"/> RE-INJURY <input type="checkbox"/> EXACERBATION <input type="checkbox"/> OTHER PLEASE EXPLAIN: 	
DATE OF ONSET OF ACCIDENT/INJURY: 	
WHAT ARE YOUR MAJOR CONCERNS? 	
WHAT HAPPENED? 	
WHAT HAVE YOU DONE FOR THIS? 	
WHO HAVE YOU SEEN? 	
DID YOU LOSE TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT DATES?

INSTRUCTIONS: Please mark the area and type of pain on the drawings using the codes listed below:

N=Numbness P=Pain A=Ache
 T=Tingling S=Stiffness/Soreness



DOCTOR ONLY

DOCTOR COMMENTS:	LUMBAR ROM	CERVICAL ROM
	90 FLEXION	65 FLEXION
	30 EXTENTION	50 EXTENSION
	20 R L FLEX	45 R L FLEX
	20 L L FLEX	45 L L FLEX
	30 R ROTATION	80 R ROTATION
30 L ROTATION	80 L ROTATION	
<input type="checkbox"/> SUB SCAN <input type="checkbox"/> RE-EXAM <input type="checkbox"/> PROCEED		

D.C. SIGNATURE:	DATE:
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