Ridge Chiropractic Center
104 Ridge Rd., Suite 144, Minooka, IL 60447

Darren Cissell, D.C.
Phone: 815-467-1464 Fax: 815-521-0492

CONFIDENTIAL PATIENT UPDATE FORM

Please let our staff know of any changes in your contact information, insurance changes or health status.

IMPORTANT: If you are using insurance to supplement your care, present your insurance card(s) and I.D. to our front staff.

Bring any old or new X-Rays or MRI reports please. It may help the doctor.

Print clearly and check the appropriate boxes. Do not skip any questions. This is an important part of establishing medical necessity.

Date _____ ☐ I have new contact information

Patient Name _____ ☐ Male ☐ Female Age _____ Birth Date _____
Last Name First Name Initial

Home Phone _____ Cell Phone _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Emergency Contact _____ Relationship _____ Phone _____

EMPLOYMENT INFORMATION

Work Status ☐ Full Time ☐ Part Time ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Student ☐ Minor

Occupation _____ Physical Work Duties _____

INSURANCE INFORMATION

☐ My insurance has not changed since my last visit here

Person Responsible for Account _____ Birth Date _____ _____
Last Name First Name Initial Insurance Company

Relationship to Patient _____ Cell Phone _____ Social Security # _____

Address (If different from patient's) _____ City _____ State _____ Zip _____

Is the patient covered by additional or secondary insurance? ☐ No ☐ Yes

REASON FOR THIS VISIT

This is a: ☐ New condition ☐ Flare-up ☐ Injury ☐ Chronic Discomfort ☐ Other (explain) _____

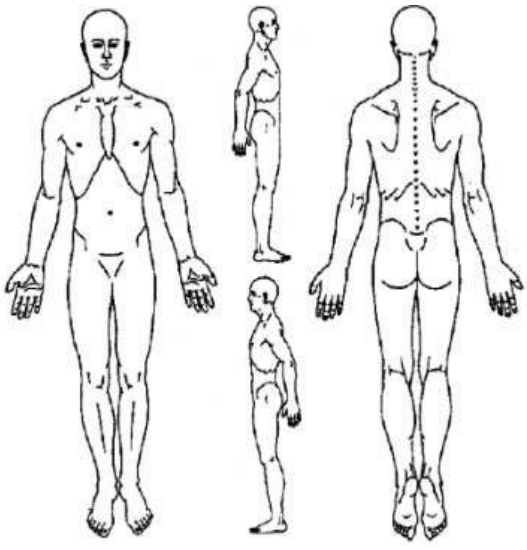
What caused this condition? Explain and check appropriate box(es) _____

☐ Not sure ☐ Work Injury ☐ After a poor night's sleep ☐ Yard work ☐ Prolonged illness
☐ Sports Injury ☐ After a slip / fall ☐ After lifting an object ☐ Sitting too long ☐ Household chores
☐ Auto Accident ☐ After a long drive / flight ☐ Reaching or overarching ☐ Other (explain) _____

When did your symptoms start (most recent date)? _____ **What was the onset?** ☐ Gradual ☐ Sudden

Have you had this condition before? ☐ No ☐ Yes If yes, when? _____

PLEASE READ: Circle any and all areas on the diagram below that bother you or that you want treated. Then, starting with your primary complaint, list all symptoms you circled on the diagram. *For example:* ***Body Area / Symptom #1:*** *Left Neck Pain / Headache;* ***Body Area / Symptom #2:*** *Lower Back Spasms, Right Leg Tingling, etc.* **Next,** on a scale from 0 to 10, with 10 being the worst, circle the number that best describes your symptom(s) at their worst lately. **Finally,** check the percent of the day you feel your symptom(s):



Body Area / Symptom(s) #1: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Body Area / Symptom(s) #2: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Body Area / Symptom(s) #3: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

Body Area / Symptom(s) #4: _____

(Absent) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Agonizing)

% of Day ☐ Constant (100%) ☐ Frequent (75%) ☐ Intermittent (50%) ☐ Occasional (25%)

My initials certify that the above information is true and complete to the best of my knowledge. Patient (or Guardian's) initials_____ Date_____

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Patient Name _____ Date _____

If your answers to the following questions 1 through 5 vary for each symptom listed on the previous page, ask for 'Additional Symptoms" page from our staff.

1. Check ALL that aggravate your symptom(s)

☐ Bending Neck Forward ☐ Turning Head to Right ☐ Twisting Left at Waist ☐ Sitting ☐ Running
☐ Bending Neck Backward ☐ Bending Forward at Waist ☐ Twisting Right at Waist ☐ Standing ☐ Changing Positions
☐ Tilting Head to Left ☐ Bending Backward at Waist ☐ Getting Up from Sitting ☐ Lifting ☐ Chewing
☐ Tilting Head to Right ☐ Tilting Left at Waist ☐ Coughing/Sneezing ☐ Driving ☐ Climbing Stairs
☐ Turning Head to Left ☐ Tilting Right at Waist ☐ Any Movement ☐ Walking ☐ Other (Explain) _____

2. Check ALL that relieve your symptom(s)

☐ Nothing ☐ Sitting ☐ Heat ☐ Exercise ☐ Standing ☐ Muscle Relaxers ☐ Chiropractic ☐ Massage
☐ Resting ☐ Ice ☐ Stretching ☐ Walking ☐ Pain Medication ☐ Physical Therapy ☐ Other (explain) _____

3. Check ALL that describe your symptom(s)

☐ Achy / Dull ☐ Stiff ☐ Sharp ☐ Throbbing ☐ Deep ☐ Shooting ☐ Numb ☐ Pins/Needles
☐ Tight ☐ Spasms ☐ Burning ☐ Stabbing ☐ Nagging ☐ Tingling ☐ Other (Explain) _____

4. Is the symptom(s) worse at certain times of the day or night? (check ALL that apply):

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by the time of day

5. Does the symptom(s) radiate, shoot or travel to another part of your body? ☐ No ☐ Yes If yes, where? _____

What have you done to relieve your symptom(s)?

☐ Nothing ☐ Prescription medication ☐ Physical therapy ☐ Massage ☐ Ice ☐ Acupuncture
☐ Rest ☐ Over-the-counter drugs ☐ Chiropractic ☐ Surgery ☐ Heat ☐ Other (Explain) _____

Were any other doctors or therapists seen for this condition? ☐ No ☐ Yes

If yes, list all doctors or therapists, approximate date of visit(s), diagnosis, and tests findings such as X-rays, MRI's, etc. and **provide us with reports / CD's if possible**.

Name	Date of Visit	Diagnosis	Test and Findings

Have you missed any work as a result of your condition? ☐ n/a ☐ No ☐ Yes (list dates) _____

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Ht ____'_____". Wt _____ lbs. Blood Pressure _____ /_____. Last Physical Exam Date _____. Physician's Name _____

Since your last visit here, have you had any illnesses, hospitalization, surgeries, accidents, injuries, emotional events, or treatments? ☐ No ☐ Yes

If yes, list and describe _____

List any current medications, prescription, over-the-counter, natural supplements, dose, frequency and reason (Provide list if needed) ☐ **None**

_____

List any recent medical events in your immediate family including any cause of death, age, diseases or hereditary conditions ☐ **None**

_____

Do you currently have any of the following conditions or diagnosis? ☐ **None** ☐ ALS ☐ Ankylosing Spondylitis ☐ Blood clots
☐ Cancer ☐ Disc Hernia ☐ Lyme Disease ☐ Metal Implants ☐ Multiple Sclerosis ☐ Pacemaker ☐ Rheumatoid arthritis
☐ Scoliosis ☐ Seizures ☐ Spinal fracture ☐ Spinal Malignancy ☐ Spinal surgery ☐ Stroke / TIAs ☐ Sudden Weight Loss

How is your diet? ☐ Poor ☐ Fair ☐ Good ☐ Eat very healthy **Your average sleep per night** _____ Hours

Exercise? ☐ No ☐ Yes (How often?) _____ **Daily stress level** ☐ Low / None ☐ Moderate ☐ High

Your current hobbies, sports and recreation _____

Is there anything else the doctor should know about the state of your health, current condition, progress or ways your current condition is affecting your life?

_____

(Female Only) Are you **pregnant**, or have you had any signs of pregnancy? ☐ No ☐ Yes

AUTHORIZATION FOR CARE

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, read the statement below and sign if you agree.
I instruct the chiropractor to deliver the care that, in his professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity. I may request a copy of the HIPAA Notice of Privacy Practices and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Name of Patient (Printed)	Signature of Patient	Date

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(Signature of Legal Representative if patient a minor) Relationship (e.g. Guardian or Parent if patient a minor)

FUNCTIONAL RATING INDEX

For use with **Neck and/or Back Problems** only.

Patient Signature _____ Date _____

In order to properly assess your condition, we must understand how much **your neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderate disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus Unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Can not work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Can not do any activities

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/ 2 hour	Increased pain with any standing

_____
Examiner