FIXEN CHIROPRACTIC

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ADULT UPDATE FORM

PLEASE UPDATE YOUR RECORDS WITH ANY CHANGES THAT HAVE BEEN MADE WITHIN THE LAST YEAR

Pregnant? ❒No ❒ Yes, due date? ___/___/___ Social Security # ___ ___ ___/___ ___/ ___ ___ ___ ___

Last Name_____ **Legal First Name**_____ **DOB:**____/____/_____

Preferred Name_____**Address**:_____
(City) (State) (Zip Code)

Home Phone: (____)_____-_____ **Cell phone:** (____)_____-_____ **Work phone:** (____)_____-_____
Email address:_____

Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒Legally Separated

Occupation: _____ **Employer Name**: _____

Smoking Status (*Check One*)

❒Every Day Smoker ❒Occasional Smoker ❒Former Smoker ❒Never Smoked

Will an insurance company be <u>contributing</u> to your care? ❒No ❒Yes *(If no, ask us about our wellness plans)*
Primary: _____ ***Secondary***: _____

Please list any supplements and/or vitamins you're currently taking.

Supplement Name	Dosage	Frequency	What is it for?

Please list any medications, prescription drugs, and pain killers you're taking.

Prescription Name	Dosage	Frequency	What is it for?

Do you have any allergies?

❒No ❒Yes, If so explain

Allergy Name	Reaction	Onset date	Additional comments
		___/___/____	
		___/___/____	
		___/___/____	

Have you had any surgeries *in the past year*?

❒No ❒Yes, If so explain

Type of Surgery	Date	What was it for?	Any reaction?	
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No
	___/___/____		❒Yes	❒No

Please check all that currently apply to your health.

Ankylosing Spondilitis (M45.9) ❒	Tension Headaches (G44) ❒	IBS(K58) ❒/Crohn's (K50.90) ❒
Degenerative Disk Disease (M51, M50) ❒	Trigeminal Neuralgia (G50.0) ❒	Diverticulitis (K57.92) ❒
Facet Arthritis-Dorsopathy (M53) ❒	TMJ Disorder (M26.60) ❒	Diverticulosis(K57.90) ❒
Osteoarthritis-Extremity Joint-(M19) ❒	Vertigo(H81)❒/Dizziness(R42) ❒	Asthma (J45) ❒
Osteoporosis(M81.0)❒/Osteopenia ❒	Blood Pressure Issues ❒ High (I10) ❒Low (I95.0)	COPD (J44.9) ❒/ Emphysema (J43.9)❒
Psoriatic Arthritis (L40.9) ❒	Diabetes ❒ Type 1(E10.9) ❒Type 2 (E11.9) ❒Gestational (024.419)	Cystic Fibrosis (E84.9) ❒
Rheumatoid Arthritis (M06.9) ❒	Heart Attack (old-I25.2) ❒	Cerebral Palsy (G80.9) ❒
Scoliosis (M41) ❒	High Cholesterol (E78.5) ❒	Epilepsy (G40.9) ❒
Spondylolisthesis (M43) ❒	Thyroid Hypo(E03.9)❒/Hyper (E05.90) ❒	Multiple Sclerosis (G35) ❒
Spondylosis-Spine-DJD-(M47) ❒	Raynaud's Syndrome (I73.00) ❒	Parkinson's Disease (G20) ❒
Stenosis (M48.0) ❒	Poor circulation ❒	Stroke ❒/TIA❒
Arm Pain❒/Leg Pain ❒	Pace Maker ❒	Lupus ❒
Fibromyalgia (M79.7) ❒	Chronic Fatigue❒/Insomnia❒	Anxiety (F41.9) ❒/ Depression (F41.8) ❒
Sinus Infection ❒	Hepatitis ❒ A(B15.9) ❒ B(B19.10) ❒ C(B19.20)	Club Foot (Q66.89) ❒
Shingles (B02) ❒	Bladder Problems ❒	Gout (M1A/M1O) ❒
Headaches ❒	Kidney Stones ❒	Plantar Fasciitis(M72.2)❒/Foot Pain ❒
Cluster Headaches (G44) ❒	Irregular Cycle ❒	Other_____ ❒
Migraines (G43) ❒	Celiac's (K90.0) ❒	

Cancer

❒ Liver (C22) ❒ Pancreatic (C25) ❒Skin (C43/C44) ❒Prostate (C61) ❒ Testicular (C62) ❒ Uterine (C55) ❒ Thyroid (C73)
❒ Brain (C71) ❒ Ovarian (C56) ❒ Throat (C15) ❒ Breast (C50) ❒Colon (C18) ❒ Lung (C34)
❒Other_____

Summary of your family history. *(Please check type and list whom)*

Cancer

❒Thyroid(C73)_____ ❒Liver(C22.9)_____ ❒Ovarian(C56.9)_____ ❒Prostate(C61)_____
❒Colon(C18.9)_____ ❒Lung(C34.90)_____ ❒Brain(C71.9)_____ ❒Skin(C43.9)_____
❒Testicular(C62.90)_____ ❒Uterus(C55)_____ ❒Pancreatic(C25.9)_____ ❒Throat(C15.9)_____
❒Breast(F-C50.919/M-C50.929)_____ ❒Other_____

Diabetes

❒Type 1(E10.9)_____ ❒Type 2(E11.9)_____

Heart Attack/Disease(I25.2) ❒_____

Blood Pressure

❒High(I10)_____ ❒Low(I95.0)_____

Scoliosis(M41.9) ❒_____

Stenosis(M48.00) ❒_____

Disc Disorder

❒Thoracic/Lumbar(M51.9)_____❒Cervical(M50.90)_____

Waiver: I have been offered a copy of Fixen Chiropractic's *HIPAA HITEC consent*, and the following person(s) have permission to any and all of my records (if applicable). _____

*(signature)*_____ *(date* ___/___/___

Do you want a receipt of a clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

❒Yes ❒No

Patient Signature: _____ Date___/___/____

Office Use Only ***HT:*** ***WT:*** ***lbs*** ***BP:*** ***/*** ***O2:*** ***Pulse***

□***Verify info in CT*** □***EHR Wizard*** □***Alert*** □***Doctor*** □***Scan***