Family Chiropractic

Ron Wilcox, D.C.

Condition Update

204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501
Tel: (360) 352-8112 • Fax: (360) 352-8113

Date: ______________________

Last visit: ____________________

First Name: ______________________________ Last Name: _____________________

DOB_____________ Age ______ SSN ____________________ Male / Female

Address ____

City________________________________ State__________ Zip Code ____________

Primary Phone: ________________________

Personal Email ________________________________

How would you like to receive appointment reminders? ❑Text Message ❑Email ❑ Decline appointment reminders

Who is your Primary Care Physician? ____

Practice Name? ____

Have you had a change of insurance since we last saw you? *If yes, please show card at front desk.* ☐No ☐Yes

Electronic Health Records Information

CMS requires us to report the following information.

Has your smoking status changed since you last reported it to us? ☐No ☐Yes

If yes, circle one: Current Every day Smoker / Current Sometimes Smoker / Former Smoker Never Smoker / Smoker, Current Status Unknown / Unknown if Ever Smoked

Changes in Medical History Since Your Last Visit? *If applicable, please give a date.*

Accidents? __________ Falls? ____________ Surgeries? _____________ Fractures? ___________

Diagnosis of diabetes, heart problems, high blood pressure, Stroke or other systemic illnesses?

____

Please list your current medications. *Prescribed and Over the Counter*

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you carry an Epi-Pen? ☐No ☐Yes

Allergies? (medical or otherwise):

____

____

What is your main concern for today's visit?

____

____

How many times have you had these symptoms within the last year? ______________________

How did this episode start?

____

____

Is the pain getting: ☐ Better ☐ Worse ☐ Same

For How long? ___________________________

What makes the pain worse?

____

____

What have you tried to relieve the pain?

____

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

Key:
Numbness

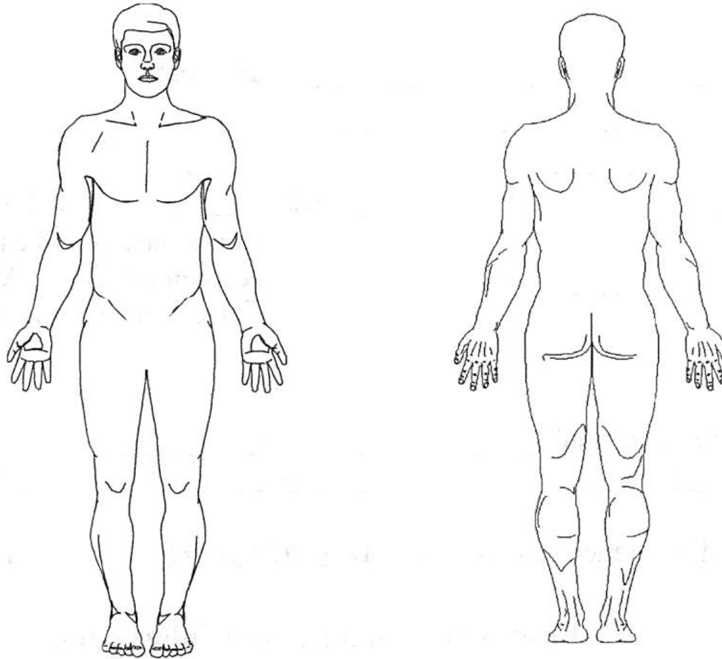
Pins and Needles
oooooooo

Burning
xxxxxxxx

Stabbing/Sharp
///////////////

Aching/Dull
****

Popping/Clicking
P P P



ASSIGNMENT AND RELEASE
I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Wilcox all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature ____ **Date** ____________________

Relationship if patient is a minor____