Cooper Chiropractic Update Form

4001 Main St Suite 200 Vancouver WA 98663 360-693-3030

Date:____________ DOB____________
Name______________________________

Address: ___________________________
City______________ State ____ Zip ______
Phone Numbers
Home: ____________ Work: ____________
Cell: ______________
Email: _____________________________

Please let us know if you have new insurance since your last visit with us

Insurance Co. _______________________
ID #: ____________________________
Group #: __________________________
Emergency Contact
Name: __________, Relationship: _______
Home: __________, Work: ___________
Cell: ______________

Reason for visit: ____

Is the complaint: *in one spot* or does it *radiate*? (circle one) If it radiates, where else do you feel it?:
____
When did your symptoms first appear? ____
Describe how you feel your problem began? ____
____
Frequency of symptoms (circle one)?
Constant (77-100%) *Frequent (51-75%)* *Occasional (26-50%)* *Intermittent (25% or less)*

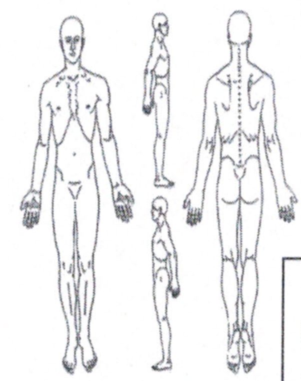
Since the condition began is it (circle one):
Better *Worse* *Same*

Is the condition worse in (circle all that apply): *AM* *PM*

If pain is one of the symptoms of your condition/injury please describe how it feels (circle all that apply):
Sharp *Dull* *Throbbing* *Numbness*
Aching *Burning* *Tingling* *Cramping*
Stiffness *Shooting* *Swelling* *Other*__________

Please rate the severity of your primary symptom (e.g. Pain) on a scale of 0 (not bothersome) to 10 (the most severe imaginable): ___

Mark figure according to the following:



X=pain

S=spasm

...

DTRs

Bi: L____R____

Tri: L____R____

B/P: L ___/___ R ___/___

What do/does the symptom(s) interfere with in your daily routine?
(circle all that apply): *Work* *Sleep* *Recreation* *Exercise*
Other: ____________
Activities or movements, which are difficult / impossible to perform due to this condition/injury
(circle all that apply): *Sitting* *Standing* *Walking* *Lying Down* *Bending*
Lifting *Typing* *Stairs* *Other*: ____________
Is there anything that you have tried that make your symptoms better? ____________________
____
Are you taking any medications for this condition/injury? ____________________
If you have any symptoms in addition to the one you listed above that you feel pertains to this condition/injury, please list: ____
____

Have you ever been treated for this condition in the past yes/no. If yes when and by whom?____

Signature____________________________________ Date______________