Adkins Chiropractic, PC
Joel F. Adkins DC
9138 Arlon Street Suite B4
Anchorage, Alaska 99507
907-333-3535
www.adkinsalaska.com
info@adkinsalaska.com

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Your Last Name

Your Social Security Number

Birth Date (MM/DD/YYYY)

Age

Your First Name

Your Middle Name (or Initial)

Gender ◯ Male ◯ Female

Race

Address

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

Ethnicity

City

State/Province

ZIP/Postal Code

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work? ◯ Yes ◯ No

City

State/Province

ZIP/Postal Code

Preferred method of contact? ◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy? ◯ Self ◯ Spouse ◯ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

I certify that any changes to my personal information have been updated above for your records.

Signature

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UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Patient Number (office use only) _____

Your Last Name _____ Your First Name _____ Your Middle Name (or Initial) _____

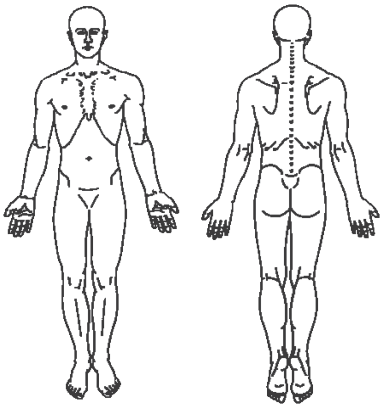
◯ **I have new contact information**

Please select one:

◯ **Progress evaluation** – I've been under active care and this is a periodic reevaluation.
◯ **New condition** – I've been under care and a new or returning condition has emerged.
◯ **Maintenance patient** – I'm under maintenance care with a new or returning health issue.
◯ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

1. Location (Where does it hurt?)
Circle the area (s) on the illustration.



2. Quality of symptoms (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other

3. Intensity (How extreme are your current symptoms?)

0 ◯—◯—◯—◯—◯—◯—◯—◯—◯—◯ 10

Absent Uncomfortable Agonizing

4. Duration and Timing (When did it start and how often do you feel it?)

◯ Constant ◯ Come and goes.

When did it start and how often? _____

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

7. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

8. What else should Dr. Adkins know about your current condition? _____

_____

_____

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	◯	◯	◯
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	◯	◯	◯
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

_____

_____

This updated patient history is for:

◯ Current Patient
Periodic Re-evaluation

◯ Current Patient
Additional Complaint/
Exacerbation

◯ Maintenance Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

◯ Inactive Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

Consultation Notes

UPDATED PATIENT HISTORY

Doctor's Initials _____

11.Medications (please list all prescription and over-the-counter): _____

_____

12. Social History (Tell Dr. Adkins about your health habits and stress levels.)

Alcohol use	◯ Daily	◯ Weekly	How much?_____	Prayer or meditation?	◯ Yes	◯ No
Coffee use	◯ Daily	◯ Weekly	How much?_____	Job pressure/stress?	◯ Yes	◯ No
Tobacco use	◯ Daily	◯ Weekly	How much?_____	Financial peace?	◯ Yes	◯ No
Exercising	◯ Daily	◯ Weekly	How much?_____	Vaccinated?	◯ Yes	◯ No
Pain relievers	◯ Daily	◯ Weekly	How much?_____	Mercury fillings?	◯ Yes	◯ No
Soft drinks	◯ Daily	◯ Weekly	How much?_____	Recreational drugs?	◯ Yes	◯ No
Water intake	◯ Daily	◯ Weekly	How much?_____			

Hobbies: _____

13. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

14. Is there anything else Dr. Adkins should know about your current condition, your progress or ways your current condition is affecting your life?

_____

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.

If the patient is a minor child, print child's full name: _____

Signature

Date (MM/DD/YYYY)

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

Adkins Chiropractic, PC
Joel F. Adkins DC