



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 _____ Race _____

Male Female

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

UPDATED CONTACT INFORMATION

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

Patient name _____

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

Patient Number
(office use only)

Alcohol use Daily Weekly How much? _____
Coffee use Daily Weekly How much? _____
Tobacco use Daily Weekly How much? _____
Exercising Daily Weekly How much? _____
Pain relievers Daily Weekly How much? _____
Soft drinks Daily Weekly How much? _____
Water intake Daily Weekly How much? _____
Hobbies: _____

Prayer or meditation? Yes No
Job pressure/stress? Yes No
Financial peace? Yes No
Vaccinated? Yes No
Mercury fillings? Yes No
Recreational drugs? Yes No

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Is there anything else Dr. Wagner 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: _____

Consultation Notes

Doctor's Initials

Wagner Chiropractic, P.A.
Dr. Ramah J. Wagner

Signature

Date (MM/DD/YYYY)