

**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)

**Gender**

Male  Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

**Marital Status**

Single  Married  Divorced

Widowed  Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

**May we contact you at work?**

Yes  No

**Preferred method of contact?**

Home Phone  Cell Phone

Work Phone  Email

Address

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

**Who carries this policy?**

Self  Spouse  Parent

First Name

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**

## UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) \_\_\_\_\_

Your Last Name \_\_\_\_\_

Your First Name \_\_\_\_\_

Your Middle Name (or Initial) \_\_\_\_\_

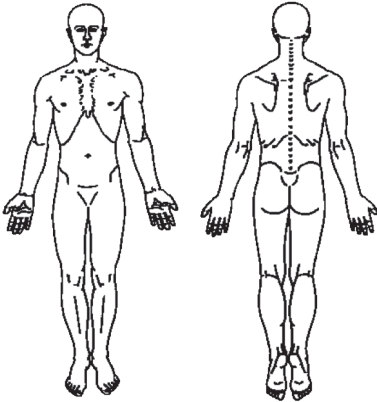
I have new contact information

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?)



**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. Stoner know about your current condition?**

\_\_\_\_\_  
 \_\_\_\_\_

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

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

**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. Social History** (Tell Dr. Stoner about your health habits and stress levels.)

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

\_\_\_\_\_  
**Patient name**

**12. 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	○	○	○	○

**13. Is there anything else Dr. Stoner 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**

**Loren R. Stoner, D.C.  
 Grand Marais  
 Wellness Center**

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date (MM/DD/YYYY)