

UPDATED CONTACT INFORMATION

Dr. Rob C. Dorn Dorn Chiropractic, LLC. 888 Thackeray Trail #210 Oconomowoc, WI 53066 dornchiropractic.com

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				
Your Last Name			○ Male ○ Female You	ur Social Security Number			
Your First Name	Your Middle Name	e (or Initial)	Birth Date (MM/DD/YYYY)				
			Marital Status				
			○ Single ○ Married ○				
Address			○ Widowed ○ Separated	d			
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				
Address			○ Work Phone ○ Ema				
City	State/Province	ZIP/Postal Code	Work Phone				
Insurance Carrier	Po	licy Number	Primary Care Provider's Name				
Insured's Last Name		Birth Date (MM/DD/YYYY)	Who carries this policy ○ Self ○ Spouse ○				
First Name	Middle Name (or I	nitial)	Ooni Oppusso Oraisiii				
Insured's Employer							
Address							
City	State/Province	ZIP/Postal Code	Employer's Phone				

JPDATED CONTACT INFORMATION



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UPDATED PATIENT HISTORY

Today's Date (MM/DD/VVVV)

Your First Name		Your Middle Name (or Initial)			
				This	
				This up history	
r active care and this is a periodic reevaluation. and a new or returning condition has emerged. ntenance care with a new or returning health issue. nactivity, I've had a relapse or an all-new health issue	ì.			Currer Period Currer Addition	
				Mainte Exacer	
 Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting Throbbing Stabbing Other 4. Duration and Tim Constant Constant Cone a When did it start and does the pain radiate, s 6. Aggravating or reworse, such as time of What tends to worse the problem? What tends to lesse 	Absent Uncom 4. Duration and Timing (When did it start and h Constant Come and goes. When did it start and how often? 5. Radiation (Does it affect other areas of your does the pain radiate, shoot or travel.) 6. Aggravating or relieving factors (What m worse, such as time of day, movements, certain and What tends to worsen the problem?			Re-Oc New E	
			idition?	——————————————————————————————————————	
ges since your most recent evaluation with us):	Wor	se Change	Improved		
nxiety, depression, headache, dizziness, pins and nee	esterol, angina, etc.		0 0 0 0		
	r active care and this is a periodic reevaluation. and a new or returning condition has emerged. Intenance care with a new or returning health issue. Inactivity, I've had a relapse or an all-new health issue. Inactivi	r active care and this is a periodic reevaluation. and a new or returning condition has emerged. ntenance care with a new or returning health issue. 2. Quality of symptoms (What does it feel like?) Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting Throbbing Stabbing Other Aggravating or relieving factors (What new store worsen the problem? What tends to worsen the problem? What lends to lessen the problem? What lese should Dr. Dorn know about you ges since your most recent evaluation with us): Worse, such as time of day, movements, certain a what tends to lessen the problem? What tends to lessen the problem? What else should Dr. Dorn know about you ges since your most recent evaluation with us): Worse, such as time of day, movements, certain a what tends to lessen the problem? What tends to lessen the problem? What else should Dr. Dorn know about you ges since your most recent evaluation with us): Worse as osteoporosis, arthritis, neck pain, back problems, poor posture, etc. Ixiety, depression, headache, dizziness, pins and needles, numbness, etc. high blood pressure, low blood pressure, high cholesterol, angina, etc.	r active care and this is a periodic reevaluation. and a new or returning condition has emerged. Intenance care with a new or returning health issue. activity, I've had a relapse or an all-new health issue. 2. Quality of symptoms (What does it feel like?) Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting Throbbing Throbbing Throbbing Other Aggravating or relieving factors (What makes it better worse, such as time of day, movements, certain activities, etc.) What tends to lessen the problem? What lends to lessen the problem? What else should Dr. Dorn know about your current con loe Heat Other Other Worse Nagory and Timing (When did it start and how often do y constant of the problem? S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.) S. Radiation (Does it affect other areas of your body? To what does the pain radiate, shoot or travel.)	r active care and this is a periodic reevaluation. and a new or returning condition has emerged. necance care with a new or returning health issue. 2. Quality of symptoms (What does it feel like?) Numbness Tingling Sliffness Dull Constant Come and goes. When did it start and how often do you feel it?) Constant Come and goes. When did it start and how often? Shagging Shooting Shooting Shooting Shooting Throbbing Shooting What tends to worsen the problem? What tends to lessen the problem? What tends to lessen the problem? What else should Dr. Dorn know about your current condition? Norse, such as time of day, movements, certain activities, etc.) What tends to lessen the problem? What tends to worsen the problem? What tends to lessen the problem? What else should Dr. Dorn know about your current condition? Improved Change Improved	

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.)	Current Patient
_	Periodic Re-evaluation

\bigcirc	Current Patient
_	Additional Complaint/
	Exacerbation

\circ	Maintenance Patient (circle one
_	Exacerbation
	Re-Occurrence
	New Enisode

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

Doctor's Initials



11. Social History (Tell Dr. D	Oorn about you	r health h	abits and s	tress level	s.)					
Alcohol use ODaily	Weekly How	much?			P	Prayer or meditation?	◯ Ye	s ONo		Patient name
Coffee use Oaily C	Weekly How	much?			J	ob pressure/stress?	◯ Ye	s ONo		
Tobacco use O Daily	Weekly How	much?			F	inancial peace?	◯ Ye	s \(\int \No		
Exercising ODaily						/accinated?	◯ Ye	s ONo		
Pain relievers ODaily						Mercury fillings?	◯ Ye	s \(\int No		
Soft drinks						Recreational drugs?	◯ Ye	s \(\int No		
Water intake O Daily) Weekly How					_				
Hobbies:										
12. Activities of Daily Livin	n (How does t	his condi	tion curren	tly interfer	e with your life and ability	to function?)				
L. Houvilloo of Burly Livin	No Effect	Mild Effect	Moderate Effect	Severe Effect	o with your mount ability	No Effect	Mild Effect	Moderate Effect	Severe Effect	
Sitting —			<u> </u>	<u> </u>	Grocery shopping —				<u> </u>	
Rising out of chair ————		<u> </u>	<u> </u>	<u> </u>	Household chores —	$\overline{}$	<u> </u>	- 0-	<u> </u>	
Standing —		<u> </u>	<u> </u>	<u> </u>	Lifting objects ———	$\overline{}$	-	<u> </u>	<u> </u>	
Walking —			<u> </u>	<u> </u>	Reaching overhead —	$\overline{}$	- O-		<u> </u>	
Lying down —		<u> </u>	<u> </u>	<u> </u>	Showering or bathing		- O-		<u> </u>	
Bending over —			<u> </u>	<u> </u>	Dressing myself ——		-	<u> </u>	<u> </u>	
Climbing stairs —			<u> </u>	<u> </u>	Love life —		-		— ○	
Using a computer —			<u> </u>	<u> </u>	Getting to sleep ———	$\overline{}$	_	_0_	<u> </u>	
Getting in/out of car————	<u> </u>		<u> </u>	<u> </u>	Staying asleep———				<u> </u>	
Driving a car				<u> </u>	Concentrating —		<u> </u>		<u> </u>	
Looking over shoulder ———			<u> </u>	<u> </u>	Exercising —	O_	<u> </u>		<u> </u>	otes
Caring for family —				_	Yard work —				_	N uc
3. Is there anything else l affecting your life?	Dr. Dorn shou	ıld know	about yo	our curre	nt condition, your prog	ress or ways your	current c	ondition i	S	Consultation Notes
meeting your me:										
To the best of my ability, th			supplied	is comp	lete and truthful. I hav	e not misrepresen	ted the p	resence,		
severity or cause of my he										
f the patient is a minor ch	ild, print chil	d's full r	name: _							
										Doctor's Initials
										Dr. Rob C. Dorn Dorn Chiropractic, LLC.

Date (MM/DD/YYYY)

Signature

Version No. 806/06529

Wersion No. 806/06529

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