



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

Ethnicity

Single Divorced

City

State/Province

ZIP/Postal Code

Widowed Separated

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



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)

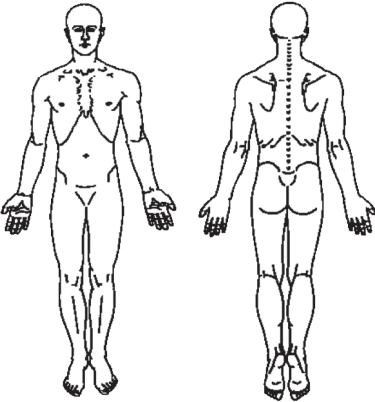
I have new contact information

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?)



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 Arizona Center for Family and Wellness Care 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): _____

Patient name

12. Social History (Tell Arizona Center for Family and Wellness Care about your health habits and stress levels.)

Patient Number
(office use only)

Alcohol use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes	<input type="radio"/> No
Coffee use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes	<input type="radio"/> No
Tobacco use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes	<input type="radio"/> No
Exercising	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes	<input type="radio"/> No
Pain relievers	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes	<input type="radio"/> No
Soft drinks	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes	<input type="radio"/> No
Water intake	<input type="radio"/> Daily	<input type="radio"/> 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		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<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"/>	Household chores	<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"/>	Lifting objects	<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"/>	Reaching overhead	<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"/>	Showering or bathing	<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"/>	Dressing myself	<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"/>	Love life	<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 to sleep	<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"/>	Staying asleep	<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"/>	Concentrating	<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"/>	Exercising	<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"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Is there anything else Arizona Center for Family and Wellness Care 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
Arizona Center for Family and Wellness Care

Signature

Date (MM/DD/YYYY)