

PATIENT UPDATE HISTORY

*In order to provide you with the finest care possible, updating your records is necessary.
May we have the following information regarding your present health status?*

Name _____ Home Phone _____

Address _____ Bus. Phone _____

City _____ State _____ Zip _____

Present Chief Complaint _____

Any recent falls, injuries, accidents or illnesses? Yes No

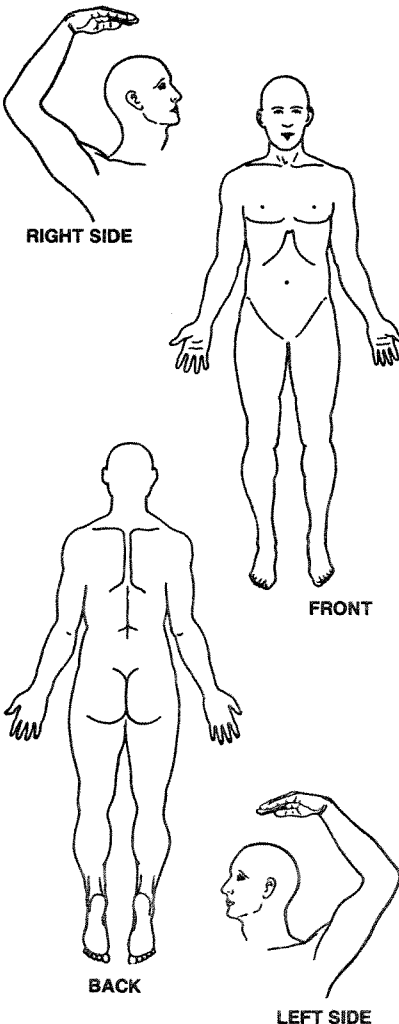
(If yes, explain) _____

Any operations, doctor or hospital care since your last visit here? Yes No

(If yes, explain) _____

Patient's Signature _____ Date _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW.



DOCTOR'S USE ONLY

Heart	B/P	P/R	Lungs	Triceps	RT	LFT	COMPARATIVE SPINAL EXAMINATION	
EENT				Biceps	_____	_____		
DYN	/	/		Petellar	_____	_____	<input type="checkbox"/> 0 <input type="checkbox"/>	
	Right	Left		Achilles	_____	_____	<input type="checkbox"/> 1C <input type="checkbox"/>	
CERVICAL		RT	LFT	Rhomberg	_____	_____	<input type="checkbox"/> 2 <input type="checkbox"/>	
Rotation		_____	_____	Trendelenburg	_____	_____	<input type="checkbox"/> 3 <input type="checkbox"/>	
Flexion		_____	_____	Finger to Nose	_____	_____	<input type="checkbox"/> 4 <input type="checkbox"/>	
Hyperext.		_____	_____	Kemp	_____	_____	<input type="checkbox"/> 5 <input type="checkbox"/>	
Lateral flex.		_____	_____	Adams	_____	_____	<input type="checkbox"/> 6 <input type="checkbox"/>	
THORACIC				Derifield	_____	_____	<input type="checkbox"/> 7 <input type="checkbox"/>	
Rotation		_____	_____	Ely	_____	_____	<input type="checkbox"/> 1T <input type="checkbox"/>	
Flexion		_____	_____	Nachlas	_____	_____	<input type="checkbox"/> 2 <input type="checkbox"/>	
Hyperext.		_____	_____	Soto Hall	_____	_____	<input type="checkbox"/> 3 <input type="checkbox"/>	
LUMBAR				Laseque	_____	_____	<input type="checkbox"/> 4 <input type="checkbox"/>	
Rotation		_____	_____	Braggard	_____	_____	<input type="checkbox"/> 5 <input type="checkbox"/>	
Flexion		_____	_____	Fajersztajn	_____	_____	<input type="checkbox"/> 6 <input type="checkbox"/>	
Hyperext.		_____	_____	Fabere	_____	_____	<input type="checkbox"/> 7 <input type="checkbox"/>	
Head Tilt		_____	_____	Kernig	_____	_____	<input type="checkbox"/> 8 <input type="checkbox"/>	
Ear High		_____	_____	Leg Lowering	_____	_____	<input type="checkbox"/> 9 <input type="checkbox"/>	
Cervical Curve		_____	_____	Hoover	_____	_____	<input type="checkbox"/> 10 <input type="checkbox"/>	
Shoulder High		_____	_____	Ankle Clonus	_____	_____	<input type="checkbox"/> 11 <input type="checkbox"/>	
Scapula High		_____	_____	Babinski	_____	_____	<input type="checkbox"/> 12 <input type="checkbox"/>	
Thoracic Curve		_____	_____	Obers	_____	_____	<input type="checkbox"/> 1L <input type="checkbox"/>	
Lumbar Curve		_____	_____	Foramina Comp	_____	_____	<input type="checkbox"/> 2 <input type="checkbox"/>	
Ilium High		_____	_____	Adsons	_____	_____	<input type="checkbox"/> 3 <input type="checkbox"/>	
				Minors	_____	_____	<input type="checkbox"/> 4 <input type="checkbox"/>	
							<input type="checkbox"/> 5 <input type="checkbox"/>	

X-RAYS TAKEN _____

Remarks _____

