Patient Update Form

ABLE BODY
HEALTH CLINIC
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Patient Information

Patient name: ____ Date of Birth: ________________
Last Middle Initial First Day / Month / Year

Has your address, or contact information changed since your last visit? ❑ NO ❑ YES

If YES, please provide your NEW contact information:

____

____

Medical Information

Have you been diagnosed with any new medical conditions since your last visit? ❑ NO ❑ YES

If YES, please describe: ____

Have you been prescribed any new medications since your last visit? ❑ NO ❑ YES

If YES, please describe: ____

Have you had any accidents, injuries, or surgeries since your last visit? ❑ NO ❑ YES

If YES, please describe: ____

Extended Health Benefits and Other Insurance

Have there been any changes to your private health insurance since your last visit? ❑ NO ❑ YES

IF YES, What is the name of your new plan (circle one):

AB Blue Cross / ASEBP / Great West Life / Chamber of Commerce / Green Shield / Manulife / Sun Life

Other: ____

Name of primary policy holder: ________________________________ DOB of policy holder________________

Insurance Policy/Plan #: ___________________________ Your ID/group #: ______________________________

Is this a Workman's Compensation Case? ❑ NO ❑ YES

Is this an automobile accident case? ❑ NO ❑ YES

I realize that my Insurance (Public or Private) may not cover 100% of the Doctors recognized fee schedule and that I am responsible for any difference between the Doctor's fee and the Insurance benefits.

Signature: ____ **Date:** ______________________________

Signature of Parent or Guardian (if applicable): ____

Patient Symptoms/Complaint

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Name: ______________________________ **Date:** ______________________________

INSTRUCTIONS:

1) Please tell us the reason for your appointment: ______________________________

2) When did this complaint begin? ______________________________

3) Have you had a similar complaint before? ❑ NO ❑ YES If Yes, how long ago? ______________

4) Have you received any tests or treatment for this complaint? ❑ NO ❑ YES If Yes, when?__________

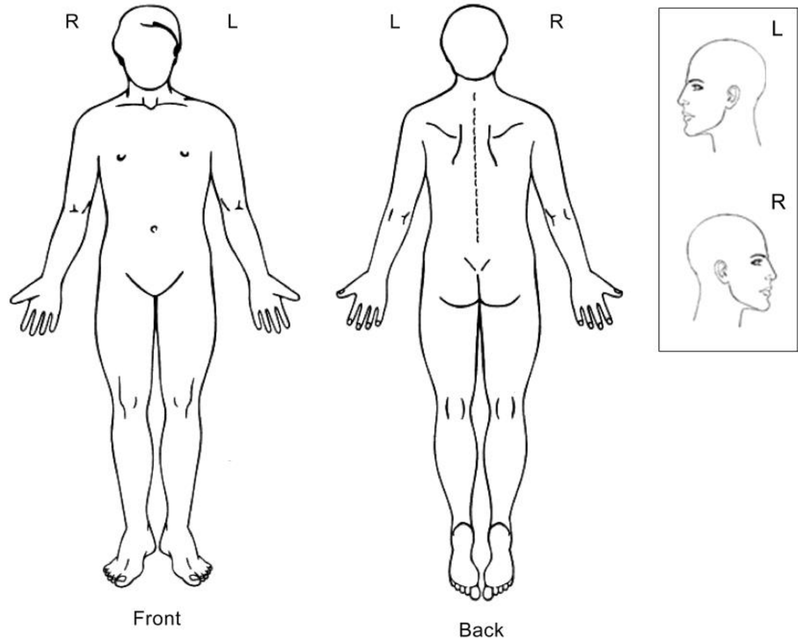
5) Please draw a face on the diagram below.

6) Please indicate how severe your pain or discomfort is today by circling the most appropriate number below:

No Pain - 0 1 2 3 4 5 6 7 8 9 10 *- Worst Pain Possible*

7) Please use the symbols provided below to mark the pain or sensations you are experiencing.

Numbness	≡≡≡≡	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	∆∆∆∆	Stiff/Tight	2222



Patient Signature: ______________________________

Doctor's Notes: