Lighthouse Chiropractic Health Center, Inc.
Self Pay Update Form

Patient Name ____ **Date** _________________________

1. **Reason for visit**?____
2. **How did your symptoms appear**? (Circle all that apply) Suddenly Gradually **Is this a pre-existing condition**? Yes No
3. **Have you experienced any of the following since your last visit?**

   (Circle all that apply) Accident Sports Injury Work Injury Fall
4. **Please describe the character of your current pain** (check all that apply) ☐ Sharp/Stabbing ☐ Sharp/Dull ☐ Aches ☐ Dull ☐ Weakness ☐ Throbbing/Gnawing ☐ Numbness/Tingling ☐ Shooting ☐ Gripping/Constricting ☐ Burning ☐ Tender/Sore
5. **How often are the complaints present**? ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)
6. Symptoms are **better** at: ☐ AM ☐ Midday ☐ PM Symptoms are **worse** at: ☐ AM ☐ Midday ☐ PM
7. **Does the pain radiate or tingle?** No Yes, to Shoulder to elbow ☐ to fingers ☐ to hip ☐ to knee ☐ to toes
8. **Are you pregnant**? Yes No Due Date _________________________

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day _______________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____________
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day_________________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _________________

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
______________________	______________________	______________________________
______________________	______________________	______________________________
______________________	______________________	______________________________
______________________	______________________	______________________________
Pharmacy Name ____		______________________________
Pharmacy Phone (____) _________________________________		

9. **Have you received any other treatment since your last visit?**

- ☐ Physical Therapy
- ☐ Home Exercises
- ☐ Trigger Point Injections
- ☐ Joint Injections
- ☐ Epidural Injections
- ☐ Anti-Inflammatory Medications
- ☐ Heat
- ☐ Tens Unit
- ☐ Braces
- ☐ Facet Injections
- ☐ Pain Medications
- ☐ Ice
- ☐ Chiropractic
- ☐ Surgery
- ☐ MRI
- ☐ Nerve Test

10. **Have you had any surgeries or hospitalization since your last visit?**? ☐ Yes ☐ No Please list:

Type of Hospitalization/Surgery:	Date	Type of Hospitalization/Surgery	Date
______________________________	__________	______________________________	__________
______________________________	__________	______________________________	__________

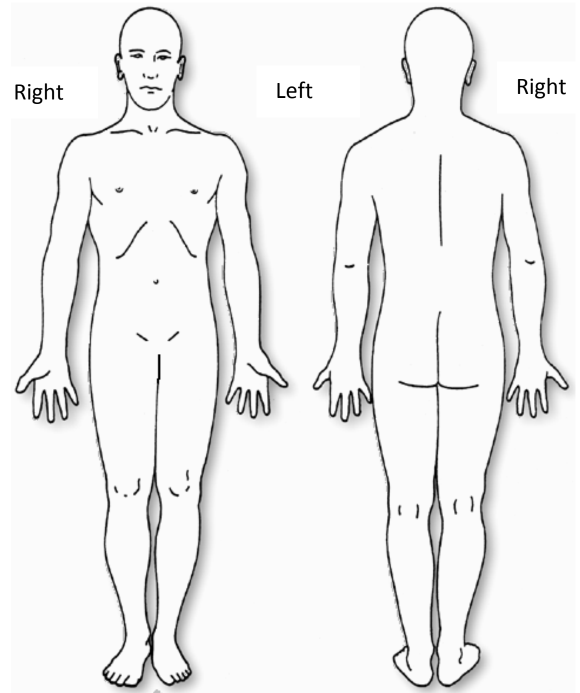
11. Have you been x-rayed or received MRI, CAT scan in the last 6-18 months? ☐ Yes ☐ No When? _______________________

12. Check those activities below during which you experience difficulty or pain:

__Lying on back	__Getting in/out of car	__Pulling	__Sitting	__Standing for long periods
__Lying on side	__Dressing Self	__Reaching	__Bending forward	__Sneezing
__Turning over in bed	__Sexual Activity	__Kneeling	__Bending forward	__Coughing
__Lying on stomach	__Pushing	__Stooping	__Walking	__Other ___________________________

13. Mark on the diagram where you are having the following symptoms:

Pain: XXX Numbness: OOO Aching: /////



14. Pain Scale: 0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst pain)

15. Review of Systems: Please check if you have recently experienced the following:

CONSTITUTIONAL
☐ Weight loss-last 6 months
☐ Fever
☐ Chills
☐ Night sweats

GASTROINTESTINAL
☐ Vomiting/Nausea
☐ Diarrhea
☐ Heartburn
☐ Constipation
☐ Abdominal pain

GENITO-URINARY
☐ Bladder Problems

RESPIRATORY
☐ Shortness of Breath
☐ Cough

SKIN
☐ Skin wounds or ulcers

FEMALE
☐ Possibly pregnant

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Shortness of breath w/walking

MUSCULOSKELETAL
☐ Joint pain
☐ Joint swelling

HEMATOLOGY
☐ Taking blood thinning meds

Present:

Weight: ___________ pounds

Height: _____ ft _____ inches

NERVOUS SYSTEM
☐ Blurry Vision ☐ Numbness ☐ Muscle Jerking ☐ Loss of Sleep ☐ Pain going to fingers
☐ Dizziness ☐ Fainting ☐ Ringing Ears ☐ Confusion ☐ Pain going past knee

Patient, Parent, Guardian or Personal Representative's Signature ____

Please Print Name of Patient, Parent, Guardian, or Personal Representative ____

Date ________________________________ **Relationship to Patient** ____