



UPDATED CONTACT INFORMATION

Monmouth Spine & Soft Tissue
Christopher Holmes, DC
700 Campus Dr., Ste C
Morganville, NJ 07751
732-970-3888
www.monmouthspinechiro.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)

Patient Number (office use only)

Age _____ **Gender** Male Female

Birth Date (MM/DD/YYYY) _____

Race
 American Indian Alaskan Native Asian Black or African American
 Native Hawaiian Other Pacific Islander Other White
 Decline to answer

Ethnicity
 Hispanic or Latino
 Not Hispanic or Latino
 Decline to specify

Your Last Name _____ **Your Social Security Number** _____

Your First Name _____ **Your Middle Name (or Initial)** _____

Smoking Status (age 13 and over)
 Never A Smoker Former Smoker
 Current Every Day Smoker Current Some Day Smoker
 Heavy Smoker Light Smoker

Address _____ **Marital Status** Married
 Single Divorced
 Widowed Separated

City _____ **State/Province** _____ **ZIP/Postal Code** _____ **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

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I have new contact information

Today's Date (MM/DD/YYYY)

Patient Number
(office use only)

Your Last Name

Your First Name

Your Middle Name (or Initial)

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.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint

The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

- An accident or injury
- Work Auto Other _____

- A worsening long-term problem
- An interest in: Wellness Other _____

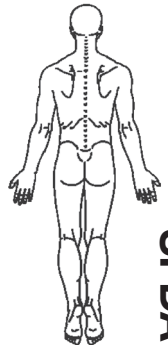
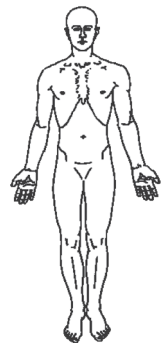
Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

Location

(Where does it hurt?)
Circle the area(s) on the illustration.
"O" for current condition
"X" for conditions experienced in the past



1. 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. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| h. Endocrine System – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Doctor's Initials

UPDATED PATIENT HISTORY

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2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

3. Medications (please list all prescription and over-the-counter): _____

4. Social History (Tell Dr. Holmes about your health habits and stress levels.)

Alcohol use Daily Weekly How much? _____
Coffee use Daily Weekly How much? _____
Tobacco use Daily Weekly How much? _____
Exercising Daily Weekly How much? _____
Pain relievers Daily Weekly How much? _____
Soft drinks Daily Weekly How much? _____
Water intake Daily Weekly How much? _____
Hobbies: _____

Prayer or meditation? Yes No
Job pressure/stress? Yes No
Financial peace? Yes No
Vaccinated? Yes No
Mercury fillings? Yes No
Recreational drugs? Yes No

5. 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
Sitting	<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"/>
Standing	<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"/>
Lying down	<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"/>
Climbing stairs	<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 in/out of car	<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"/>
Looking over shoulder	<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"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<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"/>
Lifting objects	<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"/>
Showering or bathing	<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"/>
Love life	<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"/>
Staying asleep	<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"/>
Exercising	<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"/>

6. Is there anything else Dr. Holmes should know about your current condition, your progress or ways your current condition is affecting your life?

Patient name

Patient Number
(office use only)

Consultation Notes

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Doctor's Initials

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