

GREATER ROCHESTER
family & sports
CHIROPRACTIC

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PATIENT UPDATE

NAME: _____ DATE: _____
CURRENT ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: (H) _____ (W) _____ SOCIAL SECURITY #: _____
E-MAIL ADDRESS: _____
DATE OF BIRTH: _____ STATUS: S M D SPOUSE: _____
EMPLOYER: _____
INSURANCE COMPANY: _____ POLICY HOLDER: _____
IS THIS CONDITION DUE TO A WORK-RELATED INJURY? YES NO AN AUTO ACCIDENT? YES NO
NAME OF PRIMARY CARE PHYSICIAN: _____
PHYSICIAN'S ADDRESS: _____

In order for us to best serve you, we must have all available information regarding your present health.

1. My present symptoms are: _____
2. Symptoms first appeared on: _____ Ever had similar condition? _____
3. Recent falls (please describe):

4. Recent surgery (please describe):

5. Recent accidents (please describe):

6. Recent illness: _____
7. Last Physical Exam: _____
8. Since I last saw you, I have been seen by Dr. _____ for: _____
9. Your comments: _____

Doctor's comments: _____
O: _____
P: _____
Q: _____
R: _____
S: _____
T: _____
Medications: _____

X

Patient Signature

Regional Exam:

