FAMILY HEALTH QUEST

Patient Update Form

NAME _____ DATE ____/____/____

Please fill in any information that has changed since your last visit:

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE(S) _____ E-MAIL _____

EMPLOYER _____ INSURANCE CO. _____

Reason for visit: □Wellness care Other: _____

Date you first noticed your symptoms? ____/____/____ Is this condition getting progressively worse? Y N

Activities difficult to perform? Sitting Standing Walking Bending Lying down Taking out the trash

Other_____

Is the pain constant, or does it come and go?_____ What, if any, treatment have you already received for this particular condition?_____

Name and address of other doctor(s) who have treated you for this condition_____

_____

Please use the letters below to mark the type and location of your present sensations on the diagram.

A= Ache **B**= Burning S= Sharp

N= Numbness T= Tingling D=Dull

P= Pins & Needles **S**= Stabbing

C=Cramps W=Weakness **O**= Other

SEVERITY OF PAIN
1 = least, 10 = greatest

Neck	1 2 3 4 5 6 7 8 9 10
Mid Back	1 2 3 4 5 6 7 8 9 10
Low Back	1 2 3 4 5 6 7 8 9 10
Hips	1 2 3 4 5 6 7 8 9 10
R. arm	1 2 3 4 5 6 7 8 9 10
L. arm	1 2 3 4 5 6 7 8 9 10
R. leg	1 2 3 4 5 6 7 8 9 10
L. leg	1 2 3 4 5 6 7 8 9 10