Raschke Chiropractic Center, S.C.
Preventive Family Health Care
Fred W. Raschke, D.C.

Patient History Update

Name _____ **Date**_____
First MI Last

Are there any changes to your demographics or insurance information? YES or NO

Please note any <u>changes</u> to the following:

Address _____

City, State, Zip _____

Phone # _____ Cell # _____

Marital Status M S D W Spouses first name_____

Name of Ins Co _____Group # (UHC only)_____

Occupation _____ Employer _____

We need a copy of your insurance card. Email address: _____

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Where is your pain located? _____

Describe what happened_____

_____

Work related_____ (fill out pink WC form) Auto related_____

Date symptoms began _____

Recent falls/accidents _____

Recent surgery _____

Last physical _____ Last adjustment _____

Family Physician _____

Please check if any of the following conditions apply to you:

___Cancer ___Pacemaker___ Pregnant

Are there any other changes in your health that we should know about? _____

_____

Any Changes to medications or allergies: _____

_____

_____

_____ _____

Signature:_____ Date:_____

Received a copy of HIPPA Privacy Act:

Signature:_____ Date:_____