Patient Update Form

ABLE BODY HEALTH CLINIC
www.ablebody.ca

Patient Information

Patient name: _____ Date of Birth: _____
Last First Day / Month / Year

Has your address, or contact information changed since your last visit? ❑ NO ❑ YES

If YES, please provide your NEW contact information:

Address: _____

Phone #: _____ (home / cell) Email: _____

Extended Health Benefits and Other Insurance

Have there been any changes to your private health insurance since your last visit? ❑ NO ❑ YES

IF YES, Please inform our reception staff and provide us with your new information:

What is the name of your new health insurance company? _____

Name of primary policy holder: _____ DOB of policy holder _____

Insurance Policy/Plan #: _____ Your ID/group #: _____

Is this a Workman's Compensation Case? ❑ NO ❑ YES

Is this an automobile accident case? ❑ NO ❑ YES

Medical Information

Date of last MD Visit: _____ Reason for last MD visit: _____

Since your last visit to Able Body Health Clinic:

Have you been prescribed any new medications? ❑ NO ❑ YES

If YES, please describe: _____

Have you had any accidents, injuries, or surgeries? ❑ NO ❑ YES

If YES, please describe: _____

Please check the box for any conditions you have ever been diagnosed with or told you have:

❑ Cancer	❑ Anxiety / Depression	❑ High Cholesterol
❑ Thyroid disorder	❑ Osteoporosis	❑ High Blood Pressure
❑ Diabetes	❑ Arthritis	❑ Previous Stroke or Heart Attack
❑ Other (please specify)		

I realize that my Insurance (Public or Private) may not cover 100% of the Doctors recognized fee schedule and that I am responsible for any difference between the Doctor's fee and the Insurance benefits.

Signature: _____ **Date:** _____

Signature of Parent or Guardian (if applicable): _____

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Name: _____

Date: _____

INSTRUCTIONS:

1) What is the reason for your appointment: _____

2) When did this complaint begin? _____

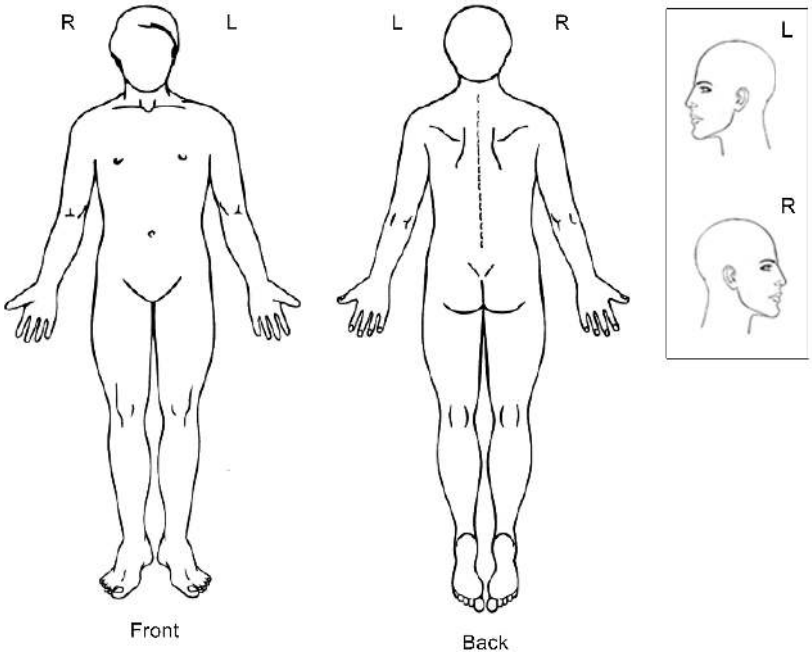
3) Have you received any other tests or treatment for this complaint? ❑ NO ❑ YES

4) Please indicate how severe your pain or discomfort is today by circling the most appropriate number below:

No Pain - 0 1 2 3 4 5 6 7 8 9 10 *- Worst Pain Possible*

5) Please use the symbols provided below to mark the pain or sensations you are experiencing.

Sensation	Symbol
Sharp	xxxx
Dull/Achy	ΔΔΔΔ
Stiff/Tight	2222
Numbness	≡≡≡≡
Pins/Needles	~~~~
Burning	oooo



***Please check the box for any symptoms that you have had in the past 1 month:**

General Symptoms	**Gastrointestinal**	**Skin**
❑ Loss of consciousness	❑ Nausea or Indigestion	❑ Rashes or itching
❑ Headache	❑ Vomiting	❑ Bruise easily
❑ Fever	❑ Blood in stool	**Cardiovascular**
❑ Night sweats	❑ Diarrhea	❑ Chest pain
❑ Weight loss/gain	❑ Constipation	❑ Swelling around ankles
❑ Night pain	**Eyes/Ears/Nose/Throat**	**Genitourinary**
❑ Loss of sleep	❑ Worsening vision	❑ Trouble urinating
Neurologic Symptoms	❑ Worsening hearing	❑ Blood in urine
❑ Dizziness	❑ Earache	❑ Incontinence
❑ Fainting	❑ Ears Ringing/Buzzing	**GU for Women**
❑ Problems speaking	**Respiratory**	❑ Painful menstruation
❑ Problems swallowing	❑ Chronic cough	❑ Hot flushes
❑ Blurred or double vision	❑ Spitting up blood	❑ Irregular/absent cycle
❑ Clumsiness	❑ Difficulty breathing	❑ Cramping/backache
❑ Numbness or tingling	❑ Pain with breathing	❑ Swollen/painful breasts