Michael H. Rogers, D.C., D.A.B.C.O.

PATIENT UPDATE

Date:_____

Name:_____DOB_____
Current Address:_____
☐ Check this box if your address has changed.
Telephone#_____Cell#_____
E-Mail Address:_____
Insurance Provider:_____ID#:_____
PCP (Primary Care Physician):_____
Employer name, address and telephone#:_____
_____
Emergency Contact:_____Telephone #:_____
Relationship to patient:_____Cell #:_____

In order for us to best serve you, we must have all available information regarding your present health. To bring our original case history up to date, would you please provide us with the following information.

Any chance of pregnancy: Yes____ No____ Due Date:_____
Do you smoke Yes____ No____ Pack(s) per day:_____
My present symptoms are:_____
_____
Recent fall or accidents:_____
Recent Xray/MRI/CTScan:_____
Where:_____
Recent Surgery:_____
_____
Last Adjustment:_____
Last Physical:_____
Since I last saw you, I have been seen by Dr._____
for_____
Current Medications:_____
_____
Allergies to Medications:_____
Other Allergies:_____

Additional Comments:_____
_____
_____
_____

Patient Signature:_____