

HEALTH HISTORY UPDATE



This form is used for any patient that has not been seen in our office (> 3 months but < 1 year since their last visit or has a new complaint/injury).

Returning Practice Member this form is meant to help us "catch up" on your health status since your last visit with our office. Completing this form indicates that you are experiencing a flare-up of the condition you were last treated for in our office.

STOP and speak to the staff: If you have experienced a Motor Vehicle Accident or Workers' Comp Injury. You will have to complete different forms. If you have experienced any substantial change in your health, you may need to complete additional paperwork and have a more extensive examination.

Name _____ Date ____/____/____

Contact Information (circle here if no change)

Address _____

City _____ St _____ Zip _____

Home Phone () _____ Cell () _____

email _____ Are you pregnant? Yes / No

Health Information

Please list the problem you are experiencing? _____

How did it happen? _____

How often do you experience this problem? 0-100% of the time ____%

How long have you been experiencing this problem? _____

On a scale from 0-10 (10 being the worst). How intense is your symptom? _____

What makes it worse? _____

What makes it better? _____

List other professionals you have seen for this condition? _____

Have you been hospitalized since we last saw you? YES / NO _____

Have you been injured since we last saw you? YES / NO _____

Have you been diagnosed with other conditions since we last saw you? YES / NO _____

I, the undersigned hereby authorize the staff to perform such services as deemed necessary by Dr. Serpe. Further I authorize assignment of my insurance rights and benefits directly to this provider and the release of such information as is needed to process insurance claims by this provider. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting or managing my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Patient Signature: _____ Date ____/____/____