CONFIDENTIAL PATIENT REACTIVATION

Name _____ Date _____

Current Address _____ City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____ Cell Phone _____

Occupation/Employer _____ Email Address _____

Health Information:

What are your present symptoms?_____

_____

How long have you had this condition?_____ Have you had similar conditions in the past? _____

Other complaints: _____

Recent Falls: _____

Recent Surgery: _____

Recent Accidents: _____

Last Physical: _____

Last Adjustment: _____

Since I last saw you, I have been seen by Dr. _____ for _____.

Is there anything else I should know about your present health? _____

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Doctor's Comments: _____

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