R.A. Dr. Roberto Arias
Chiropractic Physicians

PATIENT HISTORY UPDATE

Please complete this questionaire. This confidential history will be part of your permanent record. Thank You.

Name: _____ Date:_____

Phone ( ) _____ Cell ( ) _____Work Phone _____

Date of Birth : _____ SS # _____

E-mail: _____

If there has been change in your address, please update below:

Address: _____ City _____ ST _____ Zip _____

Please describe in your own words the new condition you are experiencing:

How long have you had this condition?

Do any position make if feel worse?

Do any position make if feel better?

Is this condition interfering with your: Work Sleep Dialy Routine other

Other Doctors or Therapist who have treated THIS condition:

What you think cause this condition?

Signature **Date:**

Parent / Guardian **Date:**

103 West Oak St. Ste. C Kissimmee, FL 34741 Phone (407) 847-8070- Fax (407) 847-6330

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: ____ lbs., and height, ____ Ft. ____ In..

Please describe your condition:

_____

_____

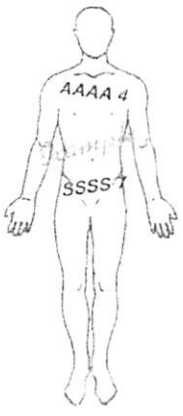
Signature: _____ Date: ___/___/___

SHOW US WHERE IT HURTS

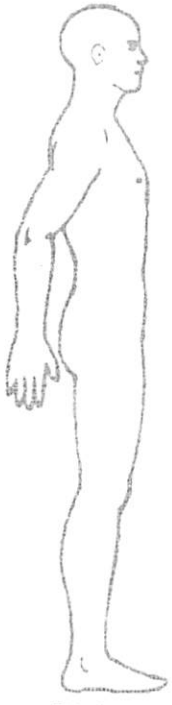
Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description ➤	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol ➤	NNNN	PPPP	BBBB	AAAA	SSSS

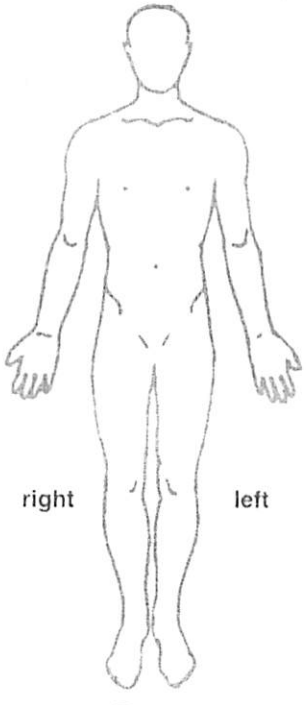
◯ Circle any area of pain not represented by a symbol.



Example

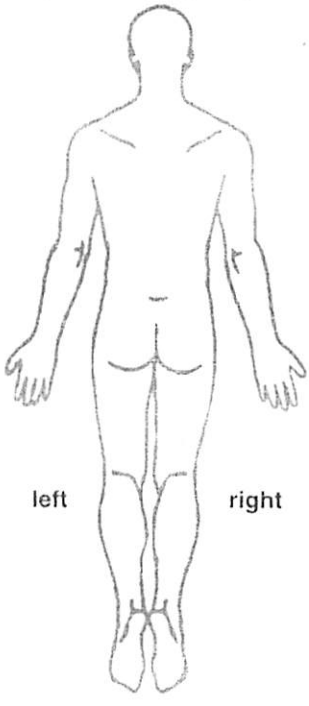


Right



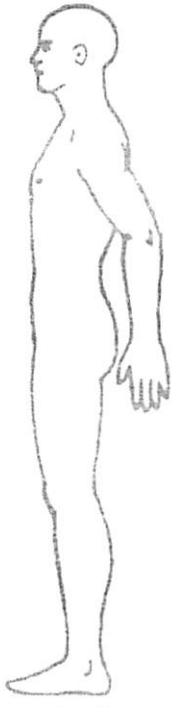
right left

Front



left right

Back



Left

DOCTOR'S NOTES

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

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COVID-19 QUESTIONAIRE

- Have you been tested for COVID-19 in the past14 days?
  Yes____ No____
- If yes, have you tested positive or negative?
  Positive____ Negative____
- Have you had any of the following symptoms?
  - Fever or Chills Yes____ No____
  - Cough Yes____ No____
  - Difficulty breathing Yes____ No____
  - Fatige Yes____ No____
  - Muscle or body pain Yes____ No____
  - Headache Yes____ No____
  - New loss of taste or smell Yes____ No____
  - Sore Throat Yes____ No____
  - Congestion or runny nose Yes____ No____
  - Nausea or vomiting Yes____ No____
  - Diarrhea Yes____ No____

If you have tested positive for COVID-19 in the past 14 days, please provide us with your results sheet showing a negative test.

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