OUCH

ACCIDENT
ACHES
ALLERGIES
BUMPS
COLDS
CONSTIPATION
FALLS
FATIGUE
HEADACHES
INDIGESTION
NERVOUSNESS
SELF-ADMINISTERED TREATMENT
SLEEPLESSNESS
STIFFNESS
STOMACH TROUBLE
TENSION

FORM

CHANGE OF CONDITION REPORT

If you have experienced a sudden change in your physical condition, we would like to know about it because we want your treatment to be the best possible for your present state. Your complete recounting of any discomfort you have felt, and any accidents or injuries you have had recently, even if you experienced no apparent reaction, will help us to help you more. Please provide us with the information requested below.

Name:_____ Date: _____

List any falls, accidents, or other injuries you have had since your last visit:

_____

Date of injury:_____ Time: _____

Where did it happen? _____

_____

What happened? _____

_____

List any unusual pains, discomforts, or other symptoms you have experienced as a result of this injury or since your last visit:_____

_____

_____

What have you done to try to relieve your symptoms?

_____

_____

Have you received any other care for this injury?

If so, where and what? _____

_____

_____

PLEASE COMPLETE OTHER SIDE

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