



# Shelton Chiropractic

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## PATIENT UPDATE INFORMATION

**PLEASE FILL OUT COMPLETELY.**

**Your last visit:** \_\_\_\_\_

Date: \_\_\_\_\_

Name (Mr. Mrs. Miss Ms.): \_\_\_\_\_

Last

First

MI

Address: \_\_\_\_\_

City

State

Zip Code

(H) Phone: \_\_\_\_\_ (W) Phone: \_\_\_\_\_ (C) Phone: \_\_\_\_\_

Best place to reach you: Home    Work    Cell

Email Address: \_\_\_\_\_ @ \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Marital Status:  Married     Single     Widow     Divorced

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### IN CASE OF EMERGENCY CONTACT

Name: \_\_\_\_\_ (W) Phone: \_\_\_\_\_ (C) Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Family Physician: \_\_\_\_\_

*Please check any and all insurance coverage that may be applicable in this case:*

Major Medical     Medicare     Auto Accident     Other \_\_\_\_\_

Name of your insurance company: \_\_\_\_\_

Family History:	Mother	Father	Siblings	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER
Heart Disease							
Stroke							
Cancer / Type of Cancer							

Are you pregnant?  YES     NO    Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

List all current medications & their use: \_\_\_\_\_

List all current vitamins and supplements: \_\_\_\_\_

Since your last visit please list all surgeries/ hospitalizations: \_\_\_\_\_

Please list all previous accidents and/or falls since your last visit: \_\_\_\_\_

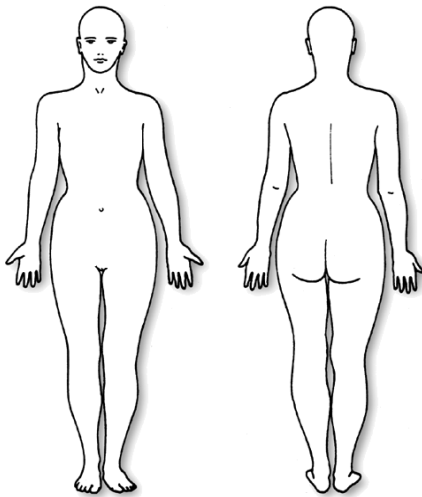
(continued on back)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for today's visit/major complaint: \_\_\_\_\_

Please list activities most affected by your condition: \_\_\_\_\_

**Please mark X on the picture where you have pain, numbness or tingling.**



Rate the severity of your pain on a scale from 1(least pain) to 10(severe pain) \_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your: work sleep daily routine recreation

Activities that are painful to perform? sitting walking bending lying down  
other \_\_\_\_\_

What makes your condition WORSE: \_\_\_\_\_

What makes your condition BETTER: \_\_\_\_\_

Is there anything else you would like Dr. Shelton to know? \_\_\_\_\_

Exercise	Working Activity	Habits	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/ Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason: _____

**PLEASE CHECK ANY AND ALL THAT APPLY TO YOU:**

**NECK:**

- Neck Pain
- Pain into your shoulders/arms/hands
- Numbness/tingling in arms/hands
- Hearing disturbances
- Weakness in grip
- High/low Blood Pressure
- Headaches
- Dizziness
- Visual disturbances
- Coldness in hands
- Thyroid conditions
- Sinusitis
- Allergies/Hay fever
- Recurrent colds/Flu
- Low Energy/Fatigue
- TMJ/Pain/Clicking

**UPPER BACK:**

- Upper thoracic pain
- Heart Murmurs
- Tachycardia
- Heart Attacks/Angina
- Heart Palpitations
- Recurrent Lung Infections/Bronchitis
- Asthma/Wheezing
- Shortness of Breath
- Pain on Deep Inspiration/Expiration

**MID BACK:**

- Mid Back Pain
- Pain into your Ribs/Chest
- Indigestion/Heartburn
- Reflux
- Nausea
- Ulcers/Gastritis
- Hypoglycemia
- Tired/Irritable after eating or when you haven't eaten for a while

**LOW BACK:**

- Low back pain
- Pain into your hips/legs/feet
- Numbness/tingling in your legs/feet
- Coldness in your legs/feet
- Muscle cramps in your legs/feet
- Constipation / Diarrhea
- Sexual dysfunction
- Weakness/injuries in your hips/knees/ankles
- Recurrent bladder infections
- Frequent/difficulty urinating
- Menstrual irregularities/cramping (females)

*It is usual and customary to pay for services the time of service, unless other arrangements are made.*

Patient Signature: \_\_\_\_\_