Terron Griffis, D.C.

Condition Update

204 Pinehurst Dr. SW, Ste. 103, Tumwater, WA 98501
Tel: (360) 352-8112 • Fax: (360) 352-8113

Date: _____
Last visit: _____

First Name: _____ Last Name: _____
DOB_____ Age _____ SSN _____ Male / Female
Address_____
City_____ State_____ Zip Code _____
Primary Phone:
_____
Personal Email
_____

How would you like to receive appointment reminders? ❑Text Message ❑Email
❑ Decline appointment reminders

Who is your Primary Care Physician? _____
Practice Name? _____

Have you had a change of insurance since we last saw you? *If yes, please show card at front desk.* □No □Yes

Electronic Health Records Information

CMS requires us to report the following information.

Has your smoking status changed since you last reported it to us? □No □Yes

If yes, circle one: Current Everyday Smoker / Current Sometimes Smoker / Former Smoker
Never Smoker / Smoker, Current Status Unknown / Unknown if Ever Smoked

Changes in Medical History Since Your Last Visit? *If applicable, please give a date.*

Accidents? _____ Falls? _____ Surgeries? _____ Fractures? _____

Diagnosis of diabetes, heart problems, high blood pressure, Stroke or other systemic illnesses?

_____

Please list your current medications. *Prescribed and Over the Counter*

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you carry an Epi-Pen? □No □Yes
Allergies? (medical or otherwise):

_____
_____

What is your main concern for today's visit?

_____
_____

How many times have you had these symptoms within the last year? _____

How did this episode start?

_____
_____

Is the pain getting: □ Better □ Worse □ Same
For How long? _____
What makes the pain worse?

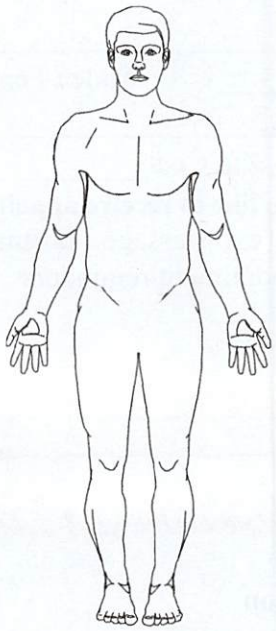
_____
_____

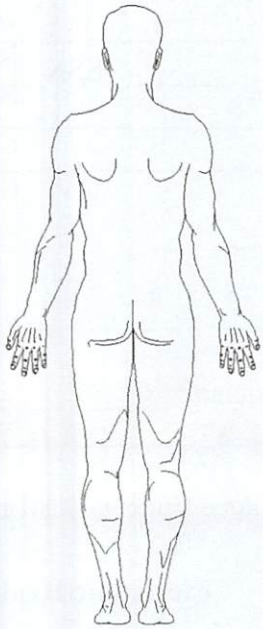
What have you tried to relieve the pain?

_____

On the pictures below, use the key on the left to shade in the areas where you are currently experiencing discomfort:

Key: Pain: P Numbness: N Tingling: T





ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Wilcox all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ **Date** _____

Relationship if patient is a minor _____

----------OFFICE USE----------

Aspirin ___/tabs ____X/day ____x/Wk _____Help Y / N Rx:_____/tabs ____X/day ____x/Wk Help Y/N
Ibupr: ___/tabs ____X/day ____x/Wk _____Help Y / N _____/tabs ____X/day ____x/Wk Help Y/N
Tylenol: ___/tabs ____X/day ____x/Wk _____Help Y / N _____/tabs ____X/day ____x/Wk Help Y/N
Aleve: ___/tabs ____X/day ____x/Wk _____Help Y / N _____/tabs ____X/day ____x/Wk Help Y/N

Condition 1 0-10:_____	Condition 2 0-10:_____	Condition 3 0-10:_____
Better:_____	Better:_____	Better:_____
Worse:_____	Worse:_____	Worse:_____
Ice/heat _____	Ice/heat _____	Ice/heat _____
R __ L / M-L _____	R __ L / M-L _____	R __ L / M-L _____
Leg:_____	Leg:_____	Leg:_____
Arm:_____	Arm:_____	Arm:_____
Timing:_____	Timing:_____	Timing:_____
Sleep _____wake_____	Sleep _____wake_____	Sleep _____wake_____
Walking _____Stairs _____	Walking _____Stairs _____	Walking _____Stairs _____
Over head: _____	Over head: _____	Over head: _____
Lifting: _____	Lifting: _____	Lifting: _____
Sitting:_____	Sitting:_____	Sitting:_____

(R -right, L –left, B/L-bilateral, T -tender, TP -trigger points, WNL – within normal limits, ↑ -increased,↓ - decreased, P -pain, J -jump sign, CW -cog wheel)

☐ Chiro-Up