Patient Update

Date _____ Home Phone _____

Email _____ Work Phone _____

Cell Phone _____

Name _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____

Responsible Party _____

Insurance Company _____

Employer _____

Check any of the following symptoms you have experienced since your last visit here:

- ☐ Low back pain
- ☐ Arm/leg numbness
- ☐ Shoulder pain/tension
- ☐ Depression
- ☐ Sinus problems
- ☐ Asthma
- ☐ Weight problems
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Sore muscles/joints
- ☐ Dizzy spells
- ☐ Digestive problems
- ☐ Fatigue
- ☐ Wrist pain
- ☐ Disc problems
- ☐ Headaches
- ☐ Insomnia
- ☐ Arthritis
- ☐ Allergies
- ☐ Nervousness
- ☐ Surgeries
- ☐ Accidents/falls
- ☐ Other concerns

Has there been any change in your family history since your initial examination? (cardiovascular disease, cancer, diabetes, stroke, etc)

_____

In case of emergency, please list a friend or relative not living in your home

Name _____ Phone _____

Address _____

Please fill out other side →

TEAM HEALTH CARE CLINIC, P.C. 12217 CHAMPLIN DRIVE CHAMPLIN, MN 55316
PHONE (763) 323-1492 FAX (763) 422 1657 TAX ID NUMBER 41-1909135

TEAM HEALTH CARE CLINIC

We are pleased to provide information and educational classes for many health conditions. Please mark any condition for which you would like to attend.

- ☐ ADD/ADHD
- ☐ Brain Fog
- ☐ Depression/Anxiety
- ☐ Dizziness/Vertigo
- ☐ Weight Loss
- ☐ Detoxification
- ☐ Sleep Difficulty
- ☐ Concussion
- ☐ Memory Decline
- ☐ Digestion Difficulty
- ☐ Fatigue
- ☐ Thyroid Imbalance
- ☐ Hormone Imbalance
- ☐ SIBO
- ☐ Cardiovascular Conditions
- ☐ Stem Cells/PRP for Joint Pain
- ☐ Lyme Disease
- ☐ Dry Eyes

Do you have a friend, family member, or coworker that you would like to have information provided to?

Name:_____

Condition:_____

Would you like us to speak on wellness related topics at your place of employment, civic group, or church?

Contact Name:_____

Phone:_____