

DR. GEORGE LENTINI
Chiropractor

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Patient Update

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email Address: _____

Employed By: _____ Occupation: _____

Is your current condition the result of: **If yes, please call our office immediately.**

_____ Auto Accident

_____ Personal Injury

_____ Workers Compensation

My Present Symptoms Are: _____

Cause Of Present Symptoms: _____

Last Adjustment: _____

Other Doctor(s) Seen: _____

For What Condition: _____

Your Primary Care Physician: _____

Other Physician: _____

Would you like your PCP or other physician to receive information about your care in this office?

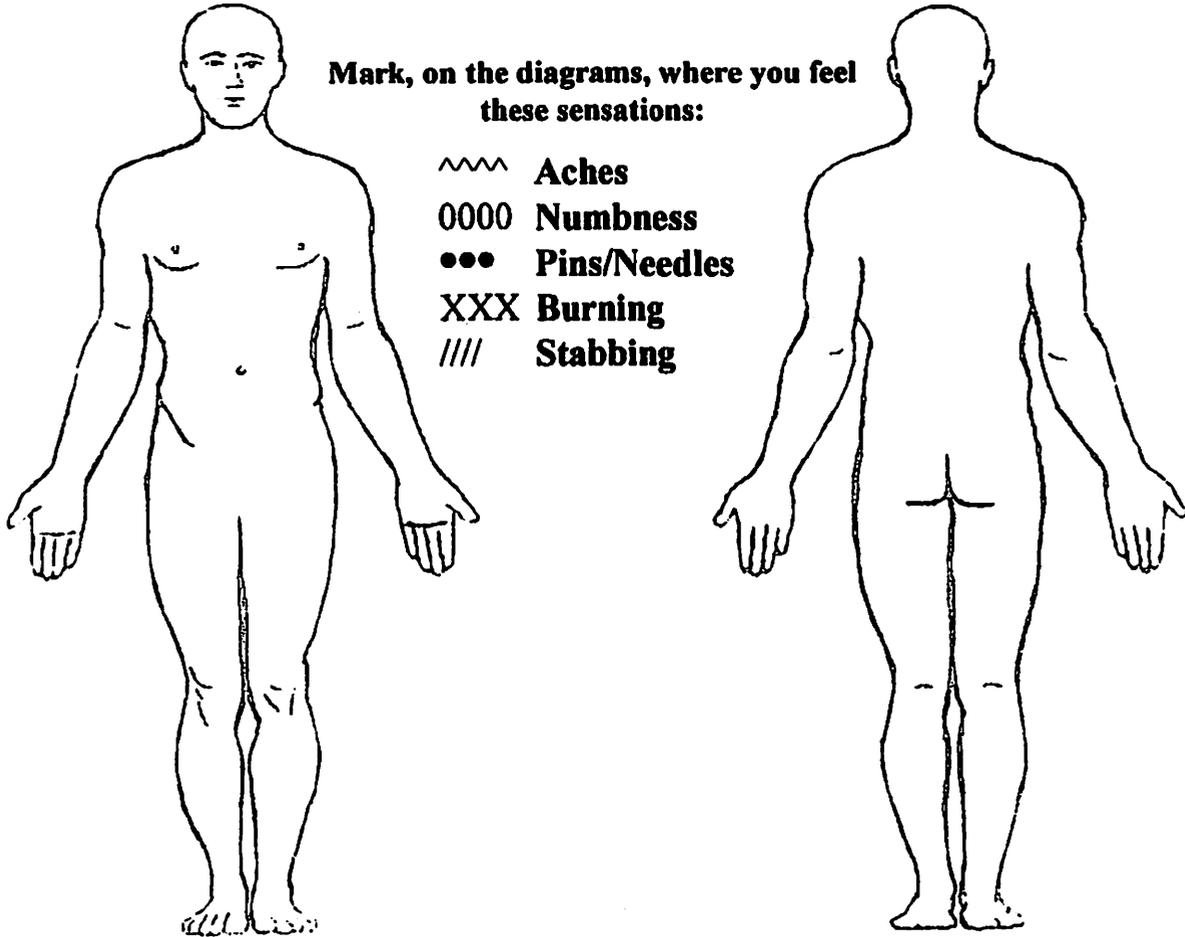
Yes: _____ No: _____

Please Complete Reverse Side of This Form



Lentini Chiropractic

Symptoms Diagram



Symptom Scale

Please indicate, by placing an X on the line below, how you presently feel your symptoms to be. (i.e.: most severe is "unbearable, I absolutely can't function")

No Symptoms _____ Most Severe Symptoms

Signature _____ Date ___/___/___