Performance and Spine Chiropractic Center

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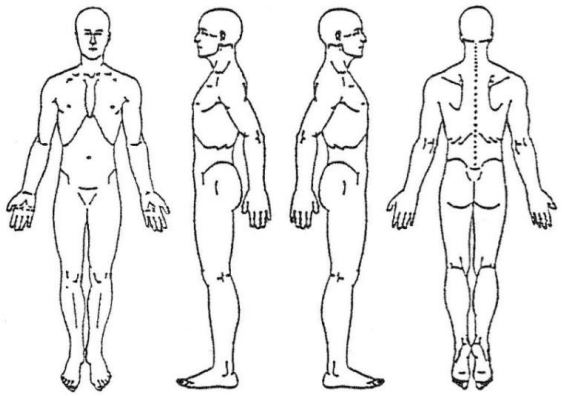
Re-examinations

Patient Name:_____ **Date:**_____/_____/_____
Any other physician treating this injury?: _____
How did your problem begin? *Specific Incident__* *Multiple Incidents__* *Gradual Onset__*
Describe how the injury occurred:_____
_____

Please mark the areas of your complaint:
XX = Pain
OO = Numbness, Tingling



Frequency (overall):
□ Constant (76-100%)
□ Frequent (51-75%)
□ Occasional (26-50%)
□ Intermittent (25% or less)

Is it getting □ **Better** □ **Worse** □ **No Change?**

Please rate your Pain/Discomfort:
0 ----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
(No pain) (Mild pain/discomfort) (Moderate pain/discomfort) (Severe pain/discomfort)

Other Complaints (I.e. Neck Pain, Low Back Pain, etc)
1._____0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10
2._____0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10
3._____0….1…..2…..3…..4…..5…..6…..7…..8…..9…..10

Physical activity at work: □ Sitting more than 50% of day □ Light manual labor □ Manual labor □ Heavy manual labor
Your general stress level: □ No stress □ Minimal stress □ Moderate stress □ Greatly stressed

Please check any additional symptoms you may be experiencing:

_blurred vision	_buzzing in ears	_cold feet	_concentration loss/confusion	_ear pain
_constipation	_diarrhea	_dizziness	_face flushed	_ears ringing
_headaches	_insomnia	_light sensitivity	_loss of balance	_nervousness
_muscle jerking	_finger numbness	_toe numbness	_tingling in arms	_tingling in legs
_tension	_loss of smell	_loss of taste	_fainting	_chest pain
_shortness of breath	_stiff neck	_upset stomach	_sleeping trouble	_depression
_cold hands	_cold sweats	_fever (in last 3 mo.)	_loss of memory	_fatigue

If a family member has had any of the following, please mark the appropriate box:

_Cancer	_Chronic Back Problems	_Chronic Headaches	_ Diabetes
_Heart Problems	_High Blood Pressure	_Other Conditions	

Patient Signature & Date ➔➔➔➔_____ _____/_____/_____

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Patient Name:_____

***For Re-exams/Updates Only*—please initial** if there has been no change on this page since your last visit: _____

IF ANYTHING HAS CHANGED SINCE YOUR LAST VISIT, PLEASE FILL OUT THE FOLLOWING:

If you have ever been treated for a listed condition in the past, please check it in the Past column.
If you are currently under the care of a medical professional for a listed condition, check it in the Present column.

Past	Present	
☐	☐	Neck Pain (M54.2)
☐	☐	Upper Back Pain (M99.72)
☐	☐	Low Back Pain (M99.73)
☐	☐	Shoulder Pain (M25.519)
☐	☐	Pain in Upper Arm or Elbow (M25.529)
☐	☐	Wrist Pain (M25.539)
☐	☐	Hand Pain (M79.646)
☐	☐	Pain in Upper Leg or Hip (M25.559)
☐	☐	Pain in Lower Leg or Knee (M79.609)
☐	☐	Pain in Ankle or Foot (M25.579)
☐	☐	Headache (R51)
☐	☐	Jaw Pain (M27.9)
☐	☐	Diabetes (E11.9)
☐	☐	High Blood Pressure (I10)
☐	☐	Chest Pains (R07.9)
☐	☐	Heart Attack (I21.3)
☐	☐	Stroke (I67.89)
☐	☐	Cancer (C80.1)
☐	☐	Blood Disorder (099.12)
☐	☐	Asthma (J45.909)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Arthritis (M12.9)
☐	☐	Rheumatoid Arthritis (M06.9)
☐	☐	Fainting (R55)
☐	☐	Dizziness (R42)
☐	☐	Pregnancy (Z33.1)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Hospitalization/Surgeries:_____
		_____
☐	☐	Liver (K76.9) / Gallbladder (K82.9) problems
☐	☐	Kidney Stones (N20.0)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (K52.9)
☐	☐	HIV/AIDS (B20)
☐	☐	Chronic Sinusitis (J32.9)
☐	☐	Irregular Menstrual Flow (N92.6)
☐	☐	Breast Soreness/Lumps (N63)
☐	☐	Painful Urination (R30.9)
☐	☐	Abdominal Pain (R10.9)
☐	☐	Heartburn/Indigestion (R12)
☐	☐	Dermatitis/Eczema/Rash (L25.9)
☐	☐	Other:_____

Past	Present	
☐	☐	Tobacco (F17.200)
☐	☐	Alcohol (F10.10) Frequent? Occasionally?
☐	☐	Drug or Alcohol Dependence (F10.20)
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: Cups/Cans

Weight: _____ pounds Height: ____ feet ____ inches

List of Medications/Vitamins_____
_____
_____

Any Known Allergies: _____
_____
_____

Doctor's additional comments/general health concerns:
_____
_____
_____

Patient Signature & Date ➔➔➔➔_____ _____/_____/_____