

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: _____

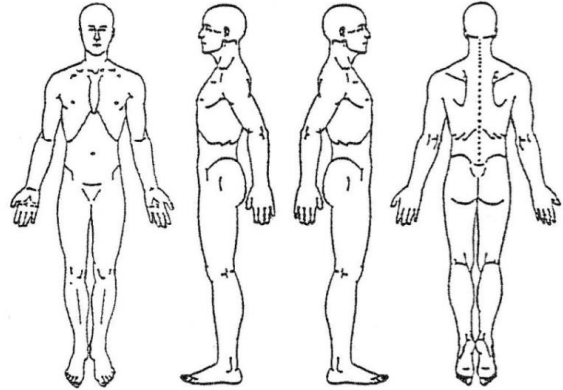
Please mark the areas of your complaint:

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:

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> cold feet | <input type="checkbox"/> concentration loss/confusion | <input type="checkbox"/> ear pain |
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> dizziness | <input type="checkbox"/> face flushed | <input type="checkbox"/> ears ringing |
| <input type="checkbox"/> headaches | <input type="checkbox"/> insomnia | <input type="checkbox"/> light sensitivity | <input type="checkbox"/> loss of balance | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> muscle jerking | <input type="checkbox"/> finger numbness | <input type="checkbox"/> toe numbness | <input type="checkbox"/> tingling in arms | <input type="checkbox"/> tingling in legs |
| <input type="checkbox"/> tension | <input type="checkbox"/> loss of smell | <input type="checkbox"/> loss of taste | <input type="checkbox"/> fainting | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> stiff neck | <input type="checkbox"/> upset stomach | <input type="checkbox"/> sleeping trouble | <input type="checkbox"/> depression |
| <input type="checkbox"/> cold hands | <input type="checkbox"/> cold sweats | <input type="checkbox"/> fever (in last 3 mo.) | <input type="checkbox"/> loss of memory | <input type="checkbox"/> fatigue |

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

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Back Problems | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> 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 |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain (M54.2) |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain (M99.72) |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain (M99.73) |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain (M25.519) |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Upper Arm or Elbow (M25.529) |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain (M25.539) |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain (M79.646) |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Upper Leg or Hip (M25.559) |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Lower Leg or Knee (M79.609) |
| <input type="checkbox"/> | <input type="checkbox"/> Pain in Ankle or Foot (M25.579) |
| <input type="checkbox"/> | <input type="checkbox"/> Headache (R51) |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain (M27.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes (E11.9) |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure (I10) |
| <input type="checkbox"/> | <input type="checkbox"/> Chest Pains (R07.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Attack (I21.3) |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke (I67.89) |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer (C80.1) |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Disorder (099.12) |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma (J45.909) |
| <input type="checkbox"/> | <input type="checkbox"/> Swelling/Stiffness of Joint(s) |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis (M12.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis (M06.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting (R55) |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness (R42) |
| <input type="checkbox"/> | <input type="checkbox"/> Pregnancy (Z33.1) |
| <input type="checkbox"/> | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> | <input type="checkbox"/> Hormonal/Estrogen Replacement |
| <input type="checkbox"/> | <input type="checkbox"/> Hospitalization/Surgeries: _____ |

- | Past | Present |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Tobacco (F17.200) |
| <input type="checkbox"/> | <input type="checkbox"/> Alcohol (F10.10) Frequent? Occasionally? |
| <input type="checkbox"/> | <input type="checkbox"/> Drug or Alcohol Dependence (F10.20) |
| <input type="checkbox"/> | <input type="checkbox"/> 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:

- | | |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Liver (K76.9) / Gallbladder (K82.9) problems |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones (N20.0) |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders (by condition) |
| <input type="checkbox"/> | <input type="checkbox"/> Colitis (K52.9) |
| <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS (B20) |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis (J32.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular Menstrual Flow (N92.6) |
| <input type="checkbox"/> | <input type="checkbox"/> Breast Soreness/Lumps (N63) |
| <input type="checkbox"/> | <input type="checkbox"/> Painful Urination (R30.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain (R10.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Heartburn/Indigestion (R12) |
| <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash (L25.9) |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____ |

Patient Signature & Date →→→→ _____ / / _____