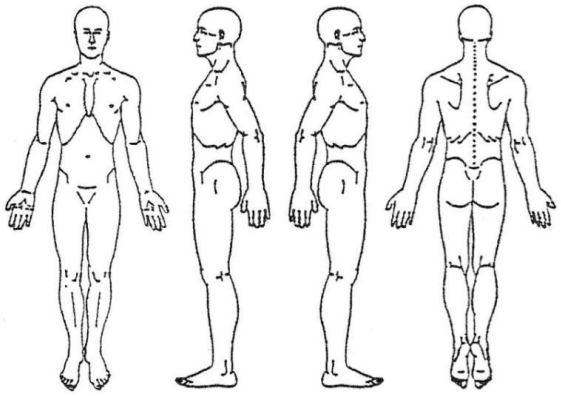
Performance and Spine Chiropractic Center
Jonathan Kinney, D.C. Heather Kinney, D.C.
19365 SW 65th Ave. Suite 104 Tualatin, OR 97062 PHONE (503) 486 – 5199 FAX (503) 486 – 5190

Re-examinations

Patient Name:_____
Date:_____/_____/_____
Primary Care Physician:_____
Other professional treating for this condition: _____
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)

0 ----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
(No pain/discomfort) (Mild pain/discomfort) (Moderate pain/discomfort) (Severe pain/discomfort)
Is it getting □ Better □ Worse □ No Change?

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	_stiff neck
_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 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 (723.1)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Wrist Pain (719.43)
☐	☐	Hand Pain (719.44)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Headache (784.0)
☐	☐	Jaw Pain (526.9)
☐	☐	Diabetes (250.0)
☐	☐	High Blood Pressure (401.9)
☐	☐	Chest Pains (786.50)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Cancer (199.1)
☐	☐	Blood Disorder (790.6)
☐	☐	Asthma (493.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Fainting (780.2)
☐	☐	Dizziness (780.4)
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Medications:_____

_____

☐	☐	Vitamins/Herbs:_____

_____

☐	☐	Hospitalization/Surgeries:_____
☐	☐	Liver (573.9) problems
☐	☐	Kidney Stones (592.0)
☐	☐	Kidney Disorders (by condition)
☐	☐	Colitis (558.9)
☐	☐	HIV/AIDS (042)
☐	☐	Gallbladder (575.9)
☐	☐	Chronic Sinusitis (473.9)
☐	☐	Irregular Menstrual Flow (626.4)
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Painful Urination (788.1)
☐	☐	Abdominal Pain (789.0)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)
☐	☐	Other:_____

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeinated Soft Drinks:

Cups/Cans

Weight: _____ pounds Height: ____ feet ____ inches

Doctor's additional comments/general health concerns:

_____
_____
_____
_____
_____