



RE-EXAMINATION QUESTIONNAIRE

NAME: _____ DATE: _____

Our goal is to offer the very highest quality care possible. Please help us by responding to the questions about your progress.

Please enter the date this episode began: _____

Do you have a new injury or new area of complaint? Yes No
Flair up of old condition? Yes No
Auto accident or work comp injury? Yes No

Complaint: # 1

Where does it hurt? _____

How often does it bother you?(please circle) Constantly 100%, 50-75%, 25-50%, occasionally 0-25%

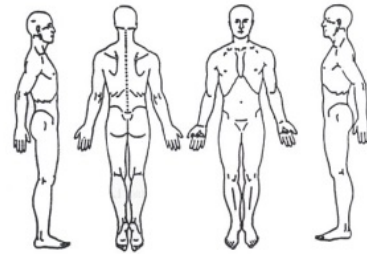
How does it feel? (Circle all that apply) acute, dull, aching, sharp, stabbing, numbness, tingling, discomfort, electric, burning, hot, cold Other: _____

Does it radiate?

- up/down arm, up/down leg, up/down neck/face, buttock, up/down back

Which side? Right left both

When did it begin? _____



Pain Assessment reported as ____/10 with 0= none 10= worst

Was it gradual/sudden

Is it aggravated by: (circle) movement sitting pushing pulling reaching lifting washing sex driving walking running twisting other: _____

Relieved by: rest ice heat meds chiropractic care massage movement other _____

Any other treatment received? _____

Perceived improvement? 0-100% How much better do you feel? _____%

Overall do you feel: Much better, a little better, same, aggravated, regressed, slightly worse, a lot worse

Does it keep you from doing any activity? (Please list i.e. work, sleep, playing with kids etc.) _____

Complaint: # 2

Where does it hurt? _____

How often does it bother you?(please circle) Constantly 100%, 50-75%, 25-50%, occasionally 0-25%

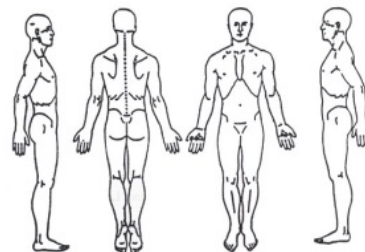
How does it feel? (Circle all that apply) acute, dull, aching, sharp, stabbing, numbness, tingling, discomfort, electric, burning, hot, cold Other: _____

Does it radiate?

- up/down arm, up/down leg, up/down neck/face, buttock, up/down back

Which side? Right left both

When did it begin? _____



Pain Assessment reported as ____/10 with 0= none 10= worst

Was it gradual/sudden

Is it aggravated by: (circle) movement sitting pushing pulling reaching lifting washing sex driving walking running twisting other: _____

Relieved by: rest ice heat meds chiropractic care massage movement other _____

Any other treatment received? _____

Perceived improvement? 0-100% How much better do you feel? _____%

Overall do you feel: Much better, a little better, same, aggravated, regressed, slightly worse, a lot worse

Does it keep you from doing any activity? (Please list i.e. work, sleep, playing with kids etc.)

Complaint: # 3

Where does it hurt? _____

How often does it bother you?(please circle) Constantly 100%, 50-75%, 25-50%, occasionally 0-25%

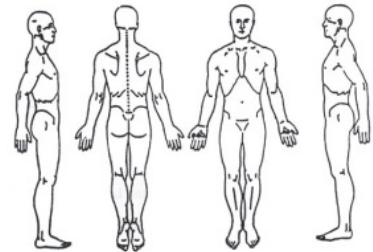
How does it feel? (Circle all that apply) acute, dull, aching, sharp, stabbing, numbness, tingling, discomfort, electric, burning, hot, cold Other: _____

Does it radiate?

- up/down arm
- up/down leg
- up/down neck/face
- buttock
- up/down back

Which side? Right left both

When did it begin? _____



Pain Assessment reported as ___/10 with 0= none 10= worst

Was it gradual/sudden

Is it aggravated by: (circle) movement sitting pushing pulling reaching lifting washing sex driving walking running twisting other: _____

Relieved by: rest ice heat meds chiropractic care massage movement other _____

Any other treatment received? _____

Perceived improvement? 0-100% How much better do you feel? _____%

Overall do you feel: Much better, a little better, same, aggravated, regressed, slightly worse, a lot worse

Does it keep you from doing any activity? (Please list i.e. work, sleep, playing with kids etc.)

S= SAME B=BETTER W=WORSE

(Please mark all that apply with appropriate letter, leave blank if not applicable)

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Numbness and Tingling | <input type="checkbox"/> Fertility |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Hand/Wrist/Elbow Pain R/L | <input type="checkbox"/> Genital Pain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain btw Shoulder Blades | <input type="checkbox"/> Menses-Cramps/Regular |
| <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Arm Pain R/L | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Gluteal Pain | <input type="checkbox"/> Body Tightness | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Body Aches | Other: _____ |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Throat Pain | _____ |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stomach Pain | _____ |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Ankle/Foot Pain R/L | _____ |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Thinking Clearer | _____ |
| <input type="checkbox"/> Muscle spasm | <input type="checkbox"/> Stress Levels | _____ |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Feeling happier | _____ |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Energy Levels | _____ |
| <input type="checkbox"/> Muscle Pains | <input type="checkbox"/> Mood | _____ |

What can you do better since beginning care? Sleep, Walk, Drive, Work, Move, Household chores, Activities of daily living, other: _____
For How long? _____

Systems Review: (since most recent evaluation). Please list any changes in your health:

- *Musculoskeletal:* Other than presenting musculoskeletal problems listed above, any new problems?

- *Neurological:* _____
- *Head & ENT:* _____
- *Cardiovascular:* _____
- *Respiratory:* _____
- *Gastrointestinal:* _____
- *Genitourinary:* _____
- *Endocrine:* _____
- *Dermatology./Hematology:* _____

Past, Family and Social History: (since initial evaluation)

- *Past Health History:* _____
 - *New Surgeries?* _____
 - *New Medications?* _____
 - *New Illnesses?* _____
 - *New Accidents?* _____
- *Family and Social History* _____
 - *Family History?* _____
 - *Work Habits?* ___4ohrs___ over4ohrs ___/hr per week ___ Very physical ___ Mildly physical ___ Sedentary other _____
- *Social Habits:* Smoker Y / N ___Packs/day___ I justquit ☺ Alcohol ___ drinks/week ___
 - *Any changes to Exercise Habits?* ___daily___ 3X week ___ Occasional ___ never other: _____
 - *Nutritional changes?* ___ Eating healthy ___ Eating poorly ___ Reduced calorie ___ New diet (which type): _____
- *Organic pain:* Where: _____ How often? _____
 - Quality of pain? _____ How did it start? _____ gradual/sudden
 - Is it aggravated by movement? Y / N Other _____ Relieved by? _____
 - Any treatment received? _____

UNEXPECTED CHANGES: _____

OVERALL, HOW ARE YOU SINCE BEGINNING OF CARE? _____

How often are you currently getting adjusted? daily 1x 2x 3x Week / 1x 2x 3x Month other _____

Is this what was recommended to you? YES/NO

DO YOU HAVE ANY SUGGESTIONS FOR US? OR ANY TESTIMONIAL YOU WOULD LIKE TO GIVE:

