HEALING HANDS CHIROPRACTIC

RE-EXAMINATION QUESTIONAIRE

NAME: _____**DATE:** _____

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

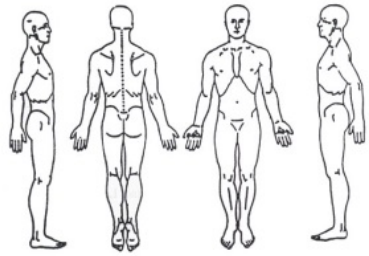
Please enter the date this episode began:_____

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
Which side? Right left both
— buttock
— up/down back



When did it begin? _____

— accident_____
— slip or fall
— long flight
— sleeping wrong
— lifting object __lbs
— over reach/arching
— household chores
— yard work
— sitting too long
— chronic prolonged illness
— other
_____
_____

_
_
_____
_____
_____
_____

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?_____

_____

_____

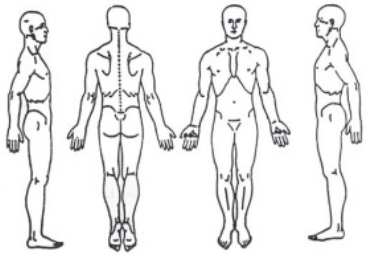
_____ _____

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
Which side? Right left both
— buttock
— up/down back



When did it begin? _____

— accident_____
— slip or fall
— long flight
— sleeping wrong
— lifting object __lbs
— over reach/arching
— household chores
— yard work
— sitting too long
— chronic prolonged illness
— other _____

_
_
_____
_____
_____
_____

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?_____

_____

_____

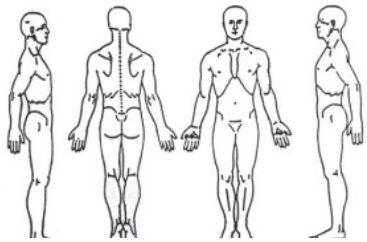
_____

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
Which side? Right left both
— buttock
— up/down back



When did it begin? _____

— accident_____	— household chores	_____
— slip or fall	— yard work	_____
— long flight	— sitting too long	_____
— sleeping wrong	— chronic prolonged	_____
— lifting object __lbs	illness	_____
— over reach/arching	— other	_____

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? _____

_____

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

_____

_____

_____

_____

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

S= SAME B=BETTER W=WORSE

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

__Chest Pain	__Numbness and Tingling	__Fertility
__Difficulty sleeping	__Hand/Wrist/Elbow Pain R/L	__Genital Pain
__Dizziness	__Pain btw Shoulder Blades	__Menses-Cramps/Regular
__Muscle Spasms	__Arm Pain R/L	__Eczema
__Gluteal Pain	__Body Tightness	__Breathing Problems
__Headaches	__Body Aches	Other:
__Low energy	__Throat Pain	_____
__Neck Pain	__Stomach Pain	_____
__Upper back pain	__Ankle/Foot Pain R/L	_____
__Mid Back Pain	__Depression	_____
__Low Back Pain	__Thinking Clearer	_____
__Muscle spasm	__Stress Levels	_____
__Hip Pain	__Feeling happier	_____
__Leg Pain	__Energy Levels	
__Muscle Pains	__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? __40hrs___over40hrs __/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:_____
  - *New Diet and 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:_____

_____
_____
_____
_____
_____