Healing Hands Chiropractic, LLC
Tracy Malton, DC
3 Hall Ave ♦ Wallingford, CT 06492 ♦ 203-626-9994

RE-EXAMINATION Progress 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.

Complaint: # 1

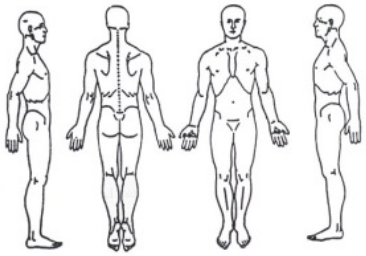
Please enter the date this episode began: _____

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

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 L, R
— up/down leg L, R
— up/down neck/face L, R
— buttock L, R
— up/down back L, R



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, standing, other: _____

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

Any other treatment received? _____

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

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.) _____

NAME: DATE:

Complaint: # 2

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

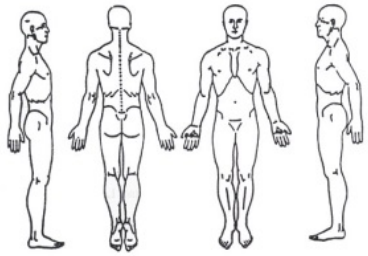
Where does it hurt?_____
_____
_____

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 L, R
— up/down leg L, R
— up/down neck/face L, R
— buttock L, R
— up/down back L, R



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, standing other: _____

Relieved by: rest, ice, heat, meds, massage, chiropractic care, movement, other_____

Any other treatment received? _____

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

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.)

_____
_____
_____

NAME: DATE:

Complaint:#3

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

Where does it hurt?_____

_____

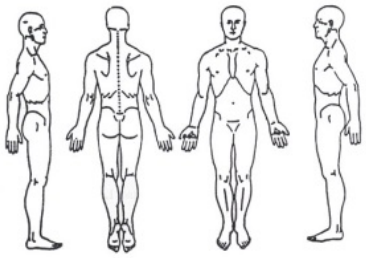
_____

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 L, R
— up/down leg L, R
— up/down neck/face L, R
— buttock L, R
— up/down back L, R



When did it begin? _____

— accident_____
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— 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, standing other: _____

Relieved by: rest, ice, heat, meds, massage, chiropractic care, movement, other_____

Any other treatment received? _____

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

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)

__Chest Pain
__Difficulty sleeping
__Dizziness
__Muscle Spasms
__Gluteal Pain
__Low Energy
__Neck Pain
__Upper back pain
__Midback pain
__Low Back Pain

__Numbness and Tingling
__Hand/Wrist/Elbow Pain R/L
__Pain btw Shoulder Blades
__Arm Pain R/L
__Body Tightness
__Body Aches
__Throat Pain
__Stomach Pain
__Ankle/Foot Pain R/L
__Depression

__Fertility
__Genital Pain
__Menses-Cramps/Regular
__Eczema
__Breathing Problems
__Stress Levels
__Feeling Happier
__Muscle Pain
__Thinking Clearer
__Energy Levels

__Hip Pain
__Leg Pain
__Mood
__Headaches
__Other
_____
_____

NAME: DATE:

What can you do better since beginning care? Sleep, Walk, Drive, Work, Move, Stand, 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:_____

_____

_____

NAME: DATE:

PRE-SCAN Checklist for: _____ Date _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

Please let us know if we need to be mindful of the following:

Drinking coffee or tea can excite the nervous system.
Have you had any of these caffeinated beverages today?

❑ **No** ❑ **Yes**
About ___ cups.

Cola drinks contain caffeine and chemicals that can affect the nervous system.
How many sodas have you had today: _____ .

Nicotine is a nervous system stimulant.
Have you used any tobacco today?

❑ **No** ❑ **Yes** How much: _____

Common, over-the-counter drugs can impact the nervous system.
Have you taken any of these types of drugs today?

❑ **No** ❑ **Yes** _____

Many prescription drugs and muscle relaxers affect the nervous system.
Have you taken any type of prescription medication today?

❑ **No** ❑ **Yes** _____

Excessive exposure to the sun affects the accuracy of your scan.
Have you had a sunburn in the last five days? ❑ **No** ❑ **Yes**

Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.
Have you used any of these products today? ❑ **No** ❑ **Yes**

Vigorous physical activity can exaggerate your scan results.
Have you had a workout today? ❑ **No** ❑ **Yes**

Stress, depression, anxiety or emotional upsets can affect nervous system tension.
Compared to a typical day, are you currently experiencing an increased level of stress? ❑ **No** ❑ **Yes**

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