

Help us Re-Evaluate Your Health

Personal Information

First: _____ MI: _____ Last: _____

Address: _____ Home Phone: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: _____

Insurance Information

Insurance Company: _____ Name of Insured: _____

Insured's Date of Birth: _____ Insured's Social Security #: _____

Insured's Employer: _____ Relationship to Insured: _____

What is your primary reason for care? _____

Is this due to a: Automobile accident Work-related injury Personal injury case None

When did your pain/symptoms begin (include date if possible)? _____

The overall severity of your complaints/concerns is:

Mild Mild to moderate Moderate Moderately severe Severe

The overall frequency is: Occasional Intermittent Frequent Constant

On a scale of 1 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

If your symptoms change, when are they worse: Morning Afternoon Evening Night NA

Are your symptoms/pain getting: Better Worse Staying the same

Do you have any additional complaints/concerns/health problems? No Yes – Please describe:

Use the following key to mark your complaints on the diagram at the right:

Pain = **P** Numbness = **N** Weakness = **W**
Soreness = **O** Stiffness = **X** Swelling = **S**
Burning = **B** Tingling = **T**

If your complaints include pain, how would you describe it?

(please check all that apply):

Aching Burning Dull Sharp Shooting

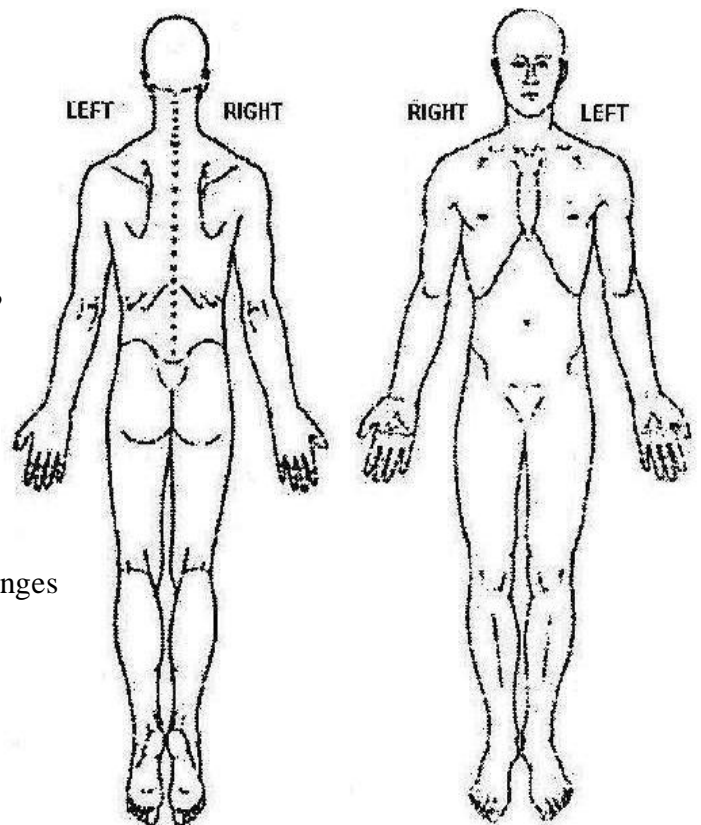
Stabbing Throbbing Other: _____

Since your symptoms began, have you noticed any

function changes: Bowel Bladder Sexual No changes

Do work activities aggravate your present complaints?

Yes No



Your Activities of Daily living and Work

Please indicate which activities of daily living are **compromised** by your current state of health:

- General:**
- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Standing | <input type="checkbox"/> Running | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lifting Children | <input type="checkbox"/> Bending | <input type="checkbox"/> Recreational activities |
| <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Reading | <input type="checkbox"/> Lying in bed | <input type="checkbox"/> Getting into/out of an automobile |
| <input type="checkbox"/> Chewing | <input type="checkbox"/> Swimming | <input type="checkbox"/> Using Keyboard | <input type="checkbox"/> Sewing or crafts |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Playing Instrument | <input type="checkbox"/> Exercising | |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Using Telephone | <input type="checkbox"/> Sitting in recliner | |
| <input type="checkbox"/> Other _____ | | | |
-

- Housework:**
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Doing laundry | <input type="checkbox"/> Vacuuming | <input type="checkbox"/> Ironing | <input type="checkbox"/> Caring for pets |
| <input type="checkbox"/> Making beds | <input type="checkbox"/> Washing dishes | <input type="checkbox"/> Carrying groceries | <input type="checkbox"/> Cooking |
-

- Yard work:**
- | | | | |
|--------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> Mowing lawn | <input type="checkbox"/> Raking leaves | <input type="checkbox"/> Gardening | <input type="checkbox"/> Shoveling snow |
|--------------------------------------|--|------------------------------------|---|
-

- Personal grooming:**
- | | | | |
|---------------------------------------|----------------------------------|--|---|
| <input type="checkbox"/> Combing hair | <input type="checkbox"/> Shaving | <input type="checkbox"/> In/out of bathtub | <input type="checkbox"/> Brushing teeth |
|---------------------------------------|----------------------------------|--|---|
-

- Travel:**
- | | | | |
|--|--|--------------------------------|--------------------------------|
| <input type="checkbox"/> Driving a car | <input type="checkbox"/> Riding in a car | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
|--|--|--------------------------------|--------------------------------|
-

About Your Progress

What percentage of your original symptoms do you still have: _____%

Specifically, in which areas have you noticed **improvements** since beginning chiropractic care?

- | | | | | | |
|---------------------------------------|-------------------------------------|---|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Energy | <input type="checkbox"/> Strength | <input type="checkbox"/> Alertness | <input type="checkbox"/> Relaxation | <input type="checkbox"/> Sleep | <input type="checkbox"/> Digestion |
| <input type="checkbox"/> Mood | <input type="checkbox"/> Pain/aches | <input type="checkbox"/> Breathing | <input type="checkbox"/> Elimination | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Menstruation | <input type="checkbox"/> Immunity | <input type="checkbox"/> Athletic Ability | <input type="checkbox"/> Movement | <input type="checkbox"/> Flexibility | <input type="checkbox"/> Concentration |
| <input type="checkbox"/> Posture | <input type="checkbox"/> Walking | <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending | <input type="checkbox"/> Working | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Traveling | <input type="checkbox"/> Standing | <input type="checkbox"/> Circulation | <input type="checkbox"/> _____ | | |
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Communication is Key to a Positive Relationship

Is there anything else you would like us to know? No Yes - _____

In which wellness subject/s would you like more educational information:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Women's health issues | <input type="checkbox"/> Men's health issues | <input type="checkbox"/> Children's health issues | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Healthy eating | <input type="checkbox"/> Nutritional supplements | <input type="checkbox"/> Healthy aging |
| <input type="checkbox"/> Posture improvement | <input type="checkbox"/> Pregnancy & childbirth | <input type="checkbox"/> Vaccination facts | <input type="checkbox"/> Immune function |
| <input type="checkbox"/> Work safety/ergonomics | <input type="checkbox"/> Stress management | <input type="checkbox"/> _____ | |
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Signature: _____

Date: _____