Patient History: Re-Exam

Name: ___________________________________ DOB:_____________________ Date: _________________

What are your symptoms? Briefly list all that apply with the most severe listed first.

1. ___________________________________ 4. ____
2. ___________________________________ 5. ____
3. ___________________________________ 6. ____

What's one thing you feel is most improved since your last exam? _______________________________________

How do you feel the motion has changed in your effected areas since beginning care?

☐ Increased but not yet normal ☐ Decreased ☐ Stayed the same ☐ Returned to normal

How do you feel the strength has changed in your effected areas since beginning care?

☐ Increased but not yet normal ☐ Decreased ☐ Stayed the same ☐ Returned to normal

Below, provide the percent you feel your symptoms have improved for each specific area you have pain. **If you do not have pain in a specific area listed, leave it blank.**

Headaches______% Jaw_____% Neck______% Mid Back______% Low Back______% Hip______%

Shoulder______% Arm_____% Hand_______% Leg_______% Foot_______% Other_____%

Using the provided pain key, mark the figure(s) below where you are experiencing pain.

R L R

L R

R L

Pain Key

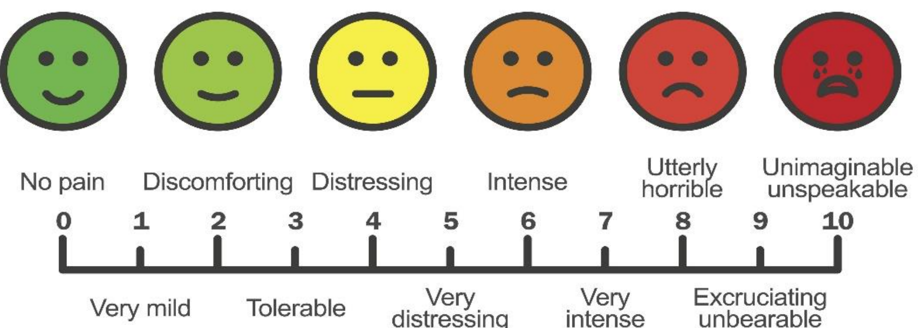
(((Achy Pain
::: Sharp Pain
XXX Burning Pain
---- Numbness
000 Pins/Needles

Try to rate **3 Activities of Daily Living** that apply to you. Firstly, mark whether the activity is *limited*, *painful* or *difficult* to do. Then, provide a number out of 10 for when the pain feels its *best*, its *worst*, on *average* this last week, and right *now*. **If an activity does not bother your symptoms, leave blank.** *L- Limited* *P- Painful* *D- Difficult*

Example: _L_ Sitting to Standing: Best _1_/10 Worst _8_/10 On average _5_/10 Right now _3_/10

____**Sitting to Standing:**	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Lifting:**	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Twist/turn:**	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Turning in bed:**	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Standing**:	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Walking:**	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Bending**:	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Sitting**:	Best ____/10	Worst___/10	On average____/10	Right now____/10
____**Using Computer:**	Best ____/10	Worst___/10	On average____/10	Right now____/10
____ **Other**:	Best ____/10	Worst___/10	On average____/10	Right now____/10

For this section, according to the areas you marked that have pain, provide a number out of 10 for when the pain is at its *best*, its *worst*, on *average*, and right *now*. **If you do not have pain in a specific area listed, leave it blank.**



Headaches:	Best:_____/10	Worst_____/10	On average_____/10	Right now_____/10
Neck:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Mid back:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Low back:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Hip:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Shoulder:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Arm:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Hand:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Leg:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Knee:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10
Foot:	Best _____/10	Worst_____/10	On average_____/10	Right now_____/10

If you have neck and/or back pain, circle your answers below when considering the last week:

1. **On average, how would you rate your pain?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
2. **How much has your pain interfered with your daily activities?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
3. **How much has your pain interfered with your recreational, social and family activities?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
4. **How much has your pain contributed to depressed feelings?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
5. **How much as your pain contributed to anxious feelings?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
6. **How have you felt your work has affected your pain?**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10
7. **How much have you been able to control your pain on your own? (10=no control)**
   Neck: 0 1 2 3 4 5 6 7 8 9 10
   Back: 0 1 2 3 4 5 6 7 8 9 10

Clinic Use Only:

Height: _____________

Weight: ____________

Blood Pressure_______/_______