

Patient Re-Activation Form – New Condition

Patient Name: _____ Pt. #: _____
Please Print

Patient Signature: _____ Date: _____

Current address: _____ Phone: _____

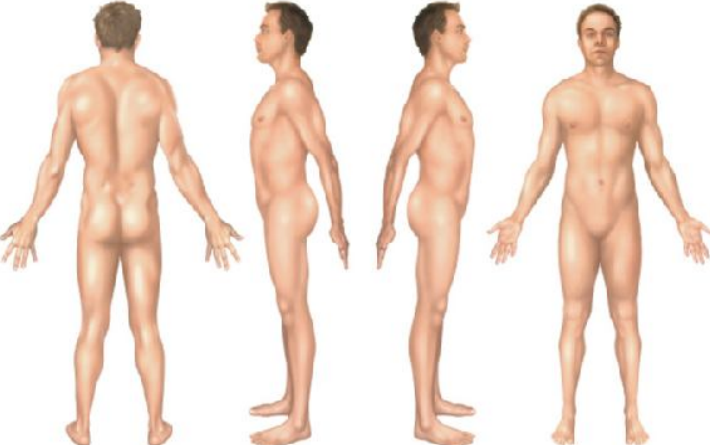
When did this episode begin/increase? _____

What do you believe is causing your symptoms? _____

Describe the nature of your symptoms. (Deep, Aching, Stiff, etc): _____

Please mark where your pain/symptoms are:

Please grade your pain on a scale of 0-10:
[0= No Pain, 10= Extreme Pain]



Choose how frequent the pain is present:

- Neck: 0 1 2 3 4 5 6 7 8 9 10
○ Constant - Frequent - Intermittent - Seldom
- Upper Back: 0 1 2 3 4 5 6 7 8 9 10
○ Constant - Frequent - Intermittent - Seldom
- Lower Back: 0 1 2 3 4 5 6 7 8 9 10
○ Constant - Frequent - Intermittent - Seldom
- Other: _____
○ 0 1 2 3 4 5 6 7 8 9 10
○ Constant - Frequent - Intermittent - Seldom

Height : _____ Weight: _____

Circle the activities that aggravate your condition:

- | | | | |
|-----------------|-------------|------------|------------|
| • stairs | • chores | • standing | • scooping |
| • sitting | • exercise | • walking | • rest |
| • stooping | • driving | • sleeping | • twisting |
| • coughing | • look down | • reaching | • sneezing |
| • looking up | • straining | • movement | • bending |
| • lying face up | • lifting | • typing | |

Circle activities that relieve your condition:

- | | | | |
|--------------|---------------|--------------|-------------------------|
| • sitting | • topical gel | • adjustment | • leaning for support |
| • ice | • not moving | • ibuprofen | • prescribed medication |
| • rest | • standing | • heat | |
| • stretching | • lying down | • knees bent | |
| • exercise | • movement | | |

Patient Name: _____ Pt. #: _____

1. Have you ever had an auto accident or work injury? Yes No
- If so, Past Year Past 5 Years Over 5 Years
 - If so, did you receive treatment? Yes No
 - If so, please list treatment.

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2. Have you seen any other providers for this condition? Yes No
- If so, please list who and when:

3. Have you had any surgeries in the past 5 years? Yes No
- If so, please list type of surgery and year:

4. Are you currently taking any medications? Yes No
- If so, please list:

5. Are there any changes to your health status since the last time we saw you? Yes No
- If so, please list:
