Patient Re-Evaluation – Existing Condition

Patient Name: _____ **Pt. # :**_____

Please Print

Patient Signature: _____ **Date:** _____

Briefly describe your symptoms: _____

_____

Is there anything that interferes with your progress or treatment? _____

_____

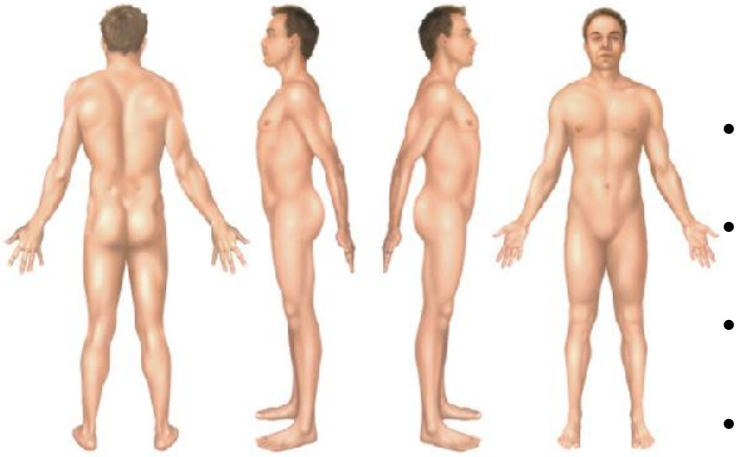
List all medications you are taking: _____

_____

List any other providers you have seen and/or imaging you have received for this condition:

_____

<u>Please Mark where your pain/symptoms are:</u>



<u>Please Grade your pain on a scale of 0-10:</u>
[0= No Pain, 10= Extreme Pain]
And
<u>Choose how Frequent the pain is present:</u>

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

<u>Please Rate your *overall* improvement since the start of your treatment:</u>

- Neck: _____%
- Upper/Mid Back: _____%
- Low-Back: _____%
- Shoulders / Arms: _____%
- Legs / Knees: _____%
- Other: _____%

Circle which ones describe your symptoms:

- dull
- sharp
- throbbing
- burning
- deep
- aching
- tingling
- stabbing
- cramping
- numbness
- radiating
- stiffness

Other symptoms:_____

Circle the activities that aggravate your condition:

- sitting
- standing
- walking
- bending
- stooping
- lifting
- sleeping
- sneezing
- coughing
- straining
- reaching
- twisting
- looking up
- looking down
- movement
- rest
- lying face down
- driving
- typing
- scooping
- house chores
- exercise
- lying face up
- stair stepping

Other aggravating factors:_____

Circle activities that relieve your condition:

- sitting
- standing
- lying
- knees bent up
- support
- no movement
- movement
- heat
- ice
- topical gel
- ibuprofen
- medication
- rest
- stretching/exercising
- adjustments

Other relieving factors:_____

Please rate your progress in the top 6 areas that are most affected by your symptoms:

- **Personal (bathe, dress)**: ____% improved
- **Lifting**: ____% improved
- **Reading**: ____% improved
- **Headache**: ____%improved
- **Frequency of Headache**: ____% improved
- **Sleeping**: ____% improved
- **Standing**: ____% improved
- **Recreation**: ____% improved
- **Throwing**: ____% improved
- **Carrying**: ____% improved
- **Pulling**: ____% improved
- **Light housework**: ____% improved
- **Heavy housework**: ____% improved
- **Lying**: ____% improved
- **Driving**: ____% improved
- **Sit to stand**: ____% improved
- **Shopping**: ____% improved
- **Bending**: ____% improved
- **Running**: ____% improved
- **Writing**: ____% improved
- **Picking up objects**: ____% improved
- **Reaching**: ____% improved
- **Reaching behind**: ____% improved
- **Pushing**: ____% improved
- **Opening jars**: ____% improved

Have you had any imaging taken since your last office visit? ☐ **Yes** ☐ **No** **List <u>when</u> and <u>where</u>.**

_____

Have you had any changes to the following?:

- **Smoking Status?** ☐ **Yes** ☐ **No**
- **Allergies to Medications?** ☐ **Yes** ☐ **No**
- **Diagnosed with Hypertension?** ☐ **Yes** ☐ **No**
- **Diagnosed with Diabetes?** ☐ **Yes** ☐ **No**
- **If <u>Yes</u> please explain changes below:**

_____

_____

For staff use (below):

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____