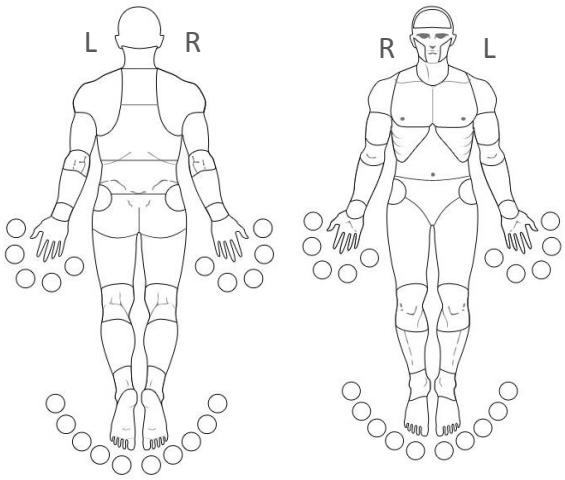
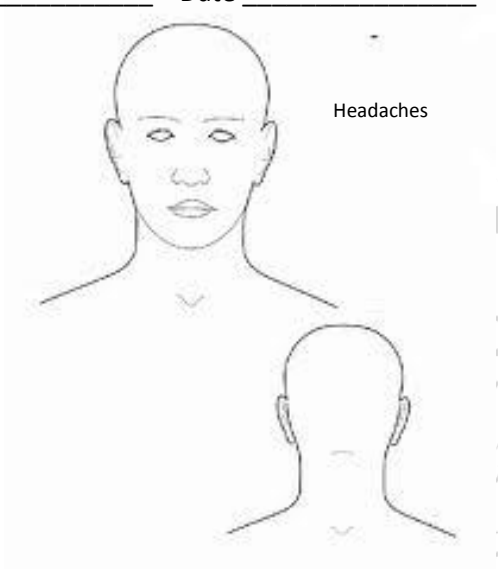
Re-Exam Health Questionnaire

Name: _____ Date _____

I. Patient Complaints:





1. Please shade in the areas on the diagram(s) where you are having pain or other symptoms

2. Please rate your pain today: (*no pain*) 0 1 2 3 4 5 6 7 8 9 10 (*excruciating*)

3. Is this a new injury? ☐ YES ☐ NO If yes, explain:_____
_____

4. Description of pain:

Please choose the description(s) that apply to your complaint.

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Tightness ☐ Swelling ☐ Weakness
☐Sharp pain ☐ Dull pain ☐ Shooting ☐ Aching ☐ Throbbing

5. Has any of your symptoms resolved since your initial treatment?

☐ NO ☐ YES If YES, explain _____

6. Frequency of complaint:

Please choose the frequency of your complaint(s) and indicate the area(s) on the body that correspond.

☐ Constant (76%-100%) _____
☐ Frequent (51%-75%) _____
☐ Occasional (26%-50%) _____
☐ Intermittent (25% or less) _____

7. How/When did your complaints begin:

☐ Unknown ☐ Suddenly ☐ Gradually
Date: _____ Comments: _____

8. What makes your symptoms worse?

☐ Nothing ☐ Sneezing ☐ Bending
☐ Reaching ☐ Standing ☐ Turning
☐ Coughing ☐ Lifting ☐ Walking
☐ Sitting ☐ Straining at stool
☐ Other: _____

9. When are your symptoms worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ All day

10. What makes your condition better?

☐ Nothing ☐ Heat ☐ Sitting ☐ Stretching
☐ Standing ☐ Rest ☐ Ice ☐ Medications
☐ Exercises ☐ Massage ☐ Chiropractic
☐ Other _____

Patient Name: _____

11. Have any of your complaints existed in the past?

☐ Neck ☐ Upper back ☐ Mid back
☐ Low Back ☐ Ribs ☐ Hands/Fingers
☐ Shoulder ☐ Arm ☐ Elbow
☐ Forearm ☐ Wrist ☐ Buttock
☐ Hip ☐ Thigh ☐ Knee
☐ Leg/Calf ☐ Ankle ☐ Foot

12. Have you had any treatment of your Condition(s) OUTSIDE this office?

☐ YES ☐ NO

If Yes list Dates, Treatments, and Doctors.

_____
_____
_____
_____

II. Headaches: If you are not suffering from headaches, you may skip this section.

1. On what date did your headaches begin?

Date: _____

☐ Same date as other symptoms
☐ Gradually
☐ Sudden

2. Description of Headache Pain:

☐ Dull ☐ Deep ☐ Aching
☐ Sharp ☐ Vice-like ☐ Burning
☐ Stabbing ☐ Throbbing/Pulsating
☐ Other _____

3. When do your headaches usually start?

☐ Constant/Anytime awake
☐ Wake up with in the morning
☐ At midday
☐ During the evening

4. What seems to bring on your headaches?

☐ Physical activity ☐ Caffeine ☐ Certain foods
☐ Menstrual Period ☐ Excessive Stress
☐ Other: _____

5. How often do your headaches occur:

☐ _____ times per week
☐ _____ times per month
☐ Other:_____

6. How long do your headaches last?

☐ Less than 1 hour ☐ From 1-3 hours
☐ Longer than 3 hours ☐ Several hours to days
☐ Other: _____

7. Do any of the following occur with your headaches?

☐ Weakness ☐ Dizziness
☐ Tremor ☐ Light/Sound sensitivity
☐ Vision problems ☐ Other: _____

8. What makes your headaches better?

☐ Nothing ☐ Rest ☐ Lying down
☐ Massage ☐ Ice/Cold packs ☐ Standing
☐ NSAIDS (Aspirin, Tylenol, etc.)
☐ Other: _____

9. Do your headaches wake you from sleep?

☐ No ☐ Sometimes ☐ Always

III. Other Complaints:

Do you have any other complaints not covered on this form? ☐ YES ☐ NO If Yes, Describe in detail here.

_____
_____

Any changes in your medical history since your initial exam? ☐ YES ☐ NO
Any changes in conditions or illnesses since your last initial exam? ☐ YES ☐ NO
If yes, please explain:_____
_____

Patient Signature		Date	