PERFORMANCE EDGE CHIROPRACTIC EVALUATION FORM

Personal Information:

Name _____ Sex: M F Age _____ Date of Birth _____

Address _____ City _____ State/Zip _____ Phone # _____

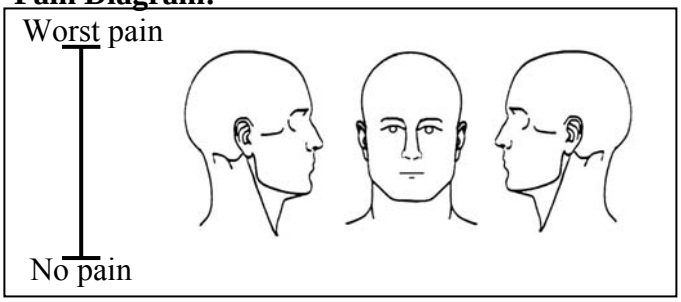
Primary Care Physician _____ Email _____

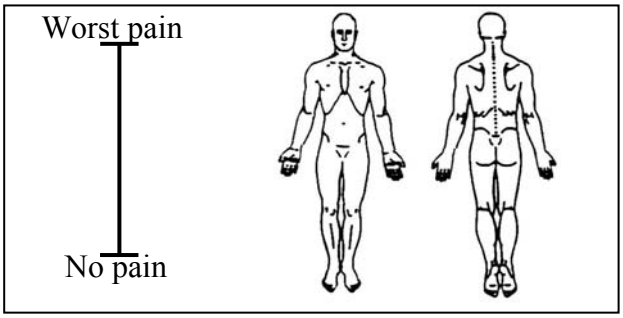
Address _____ Date of Last Visit _____

Reason for today's visit:

☐ Evaluation of pain/illness/injury ☐Accelerated Recovery ☐ Performance enhancement (no pain)

Pain Diagram:





History:

1. My chief complaint is (if none, write "none" and skip to question #6) _____
2. Describe your present symptoms if any: _____
3. When did the pain/illness or injury start? _____
4. What makes it better? _____ What makes it worse? _____
5. Do you have pain **before**, **during** or **after** activity (circle all that apply)?

6. Have you had chiropractic care before? ……..YES / NO
7. Have you been adjusted "full spine?" (neck, midback, lowback)……YES / NO
8. Other/Comments:
   _____
9. Do you have any chiropractic or other health questions you would like to have answered? YES / NO

_____

_____

Patient initial _____

Review of Systems:

Do you have or have you had problems with the following? (Check all that apply)

☐ Easy bruising/bleeding	☐ Low Back Pain /Injury	☐ Cancer	☐ Fever Chills
☐ Heart/circulation	☐ Genito-urinary system	☐ Eyes/Ears/Nose/Throat	☐ Strains/Sprains
☐ High blood pressure	☐ Osteoporosis	☐ Thyroid	☐ Weight Changes
☐ Neck Pain/Injury	☐ Arthritis	☐ Chest Pains	☐ Head Trauma
☐ Stomach/Digestion	☐ Lungs/Respiration	☐ Skin/Hair/Nails	☐ Other:_____
☐ Headaches	☐ Diabetes	☐ Kidney Disease	

☐ Surgery (ies) (List):_____

☐ Medications: _____**Patient initial** _____

(including Blood Thinners &/or Birth Control Pills: List)

Ranges of Motion:

Cervical Lumbar Other NP

Orthopedic Evaluation:

Cervical:	Pos/Neg/NP	**Lumbar:**		Pos/Neg/NP	**Other Test:**	Pos/Neg/NP
Barré-Leoiu	_____	Trendelenberg	R/L	_____	_____	_____
Distraction	_____	Becterew	R/L	_____	_____	_____
Jackson Comp	_____	Kemp	R/L	_____	_____	_____
O'Donahue	_____	SLR ____°	R/L	_____	_____	_____
_____	_____	Nachlas	R/L	_____	Dejerine's	_____

Notes: _____

_____

Neurologic Evaluation:

Motor: (indicate rating or NP)

C5	L ___/5	R___/5		L1	L ___/5	R___/5	
C6	L ___/5	R___/5		L2	L ___/5	R___/5	
C7	L ___/5	R___/5		L3	L ___/5	R___/5	
C8	L ___/5	R___/5		L4	L ___/5	R___/5	
T1	L ___/5	R___/5		L5	L ___/5	R___/5	
				S1	L ___/5	R___/5	

Sensory: (indicate <,=, >, ↓ (diminished bilaterally) or NP)

C5	L ___ R		L1	L ___ R	
C6	L ___ R		L2	L ___ R	
C7	L ___ R		L3	L ___ R	
C8	L ___ R		L4	L ___ R	
T1	L ___ R		L5	L ___ R	
			S1	L ___ R	

Reflexes: (indicate rating or NP)

Bicipital	L ___/5	R___/5
Triceps	L ___/5	R___/5
Brachioradialis	L ___/5	R___/5
Patellar	L ___/5	R___/5
Achilles'	L ___/5	R___/5
Med. Hamstring	L ___/5	R___/5
Lat. Hamstring	L ___/5	R___/5

Pathologic Reflex UE: _____

Pathologic Reflex LE: _____

Notes: _____

_____

_____

Chiropractic Evaluation:

Listings: _____

Soft Tissue Findings**:** _____

ASSESSMENT/CLINICAL IMPRESSION**:** _____

PROPOSED TREATMENT PLAN CMT-Diversified, MSTM, PIR/stretch, Home recommendations (other):

INFORMED CONSENT: I have received information about my condition and proposed treatment plan as well as alternative courses of care, the benefits, the risks and the side effects of the treatment and the consequences of not having the proposed treatment. I understand and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strains and sprains, fractures, dislocations, disc injuries and strokes. My intern and supervising faculty member have responded to all of my requests for information about the proposed treatment. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content. **By signing below I consent to chiropractic treatment.**

Patient signature: _____ Date: _____ Witness: _____

Parent if under 18 _____ **Supervisor:** _____

TREATMENT ADMINISTERED: CMT-Diversified, MSTM, PIR/stretch, Home recommendations (other)

_____

☐ Home recommendations: _____ ☐ Referral to: _____

☐ Restricted from Competition (Do Not Compete!) **Patient initial**

Abbreviations: CMT - Chiropractic manipulative therapy MSTM - Manual soft tissue massage/manipulation
NP - Not performed PIR - Post-isometric relaxation