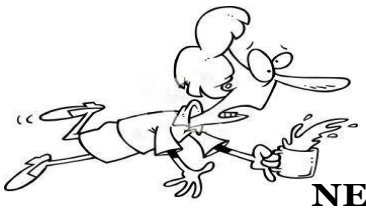


VAN ROO FAMILY CHIROPRACTIC

NEW EPISODE/INJURY/RE-EXAM FORM

FULL LEGAL NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS / P.O. BOX _____ HOME PHONE: _____

CITY / STATE / ZIP: _____ MOBILE PHONE: _____

SOCIAL SECURITY NUMBER: _____ WORK PHONE: _____

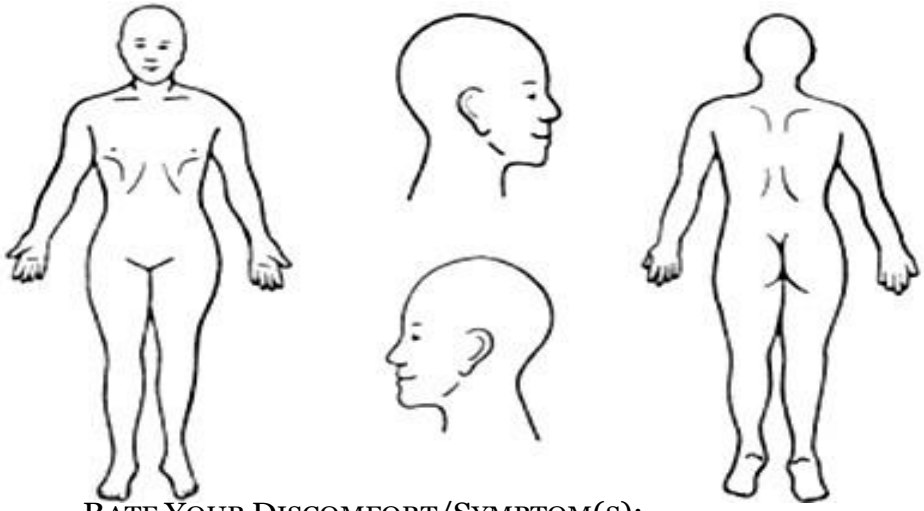
YOUR EMPLOYER: _____ JOB TITLE: _____

HISTORY OF PRESENT ILLNESS / INJURY

CHIEF COMPLAINT(S)

FILL OUT THIS SECTION BY MARKING THE AREA WITH THE DESCRIBED SENSATION USING THE APPROPRIATE SYMBOLS FROM THE LEFT.

X X X BURNING PAIN
((((ACHING PAIN
0 0 0 PINS & NEEDLES
- - - - NUMBNESS
: : : : SHARP PAIN



PLEASE COMPLETE:

____ CONSTANT
____ COME & GO
_____
____ GETTING BETTER ____
____ GETTING WORSE ____
____ STAYING SAME ____
_____

BETTER:	WORSE:
_____ AM	_____
_____ MID-DAY	_____
_____ PM	_____

RATE YOUR DISCOMFORT/SYMPTOM(S):

ENTER THE NUMBER BELOW THAT CORRESPONDS WITH YOUR DEGREE OF DISCOMFORT. **"0"** IS NO PAIN/SYMPTOM(S), **"100"** IS INTOLERABLE PAIN.

0 = NO PAIN/SYMPTOMS, 100 = INTOLERABLE PAIN

NECK (0= NO PAIN):		**MID BACK (0= NO PAIN):**		**LOW BACK (0= NO PAIN):**		_____:		_____:	
NOW:	/100	NOW:	/100	NOW:	/100	NOW:	/100	NOW:	/100
BEST:	/100	BEST:	/100	BEST:	/100	BEST:	/100	BEST:	/100
WORST:	/100	WORST:	/100	WORST:	/100	WORST:	/100	WORST:	/100
USUAL:	/100	USUAL:	/100	USUAL:	/100	USUAL:	/100	USUAL:	/100

HISTORY OF PRESENTING INJURY/ILLNESS:

SYMPTOMS DEVELOPED FROM: ☐WORK – RELATED INJURY ☐AUTO ACCIDENT ☐OTHER: _____

WHEN DID SYMPTOMS BEGIN? _____ HAVE YOU MISSED WORK? ☐YES ☐NO HOW MUCH? _____

EXPLAIN MORE ABOUT HOW THE SYMPTOMS CAME ON AND/OR DESCRIBE THE SYMPTOMS IN MORE DEPTH: _____

WHAT MAKES THE CONDITION BETTER?

HEAD / NECK _____ SHOULDER, ARM, HAND _____

MID BACK _____ HIP, LEG, FOOT _____

LOW BACK _____ OTHER _____

ACTIVITIES OF DAILY LIVING

INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES. PLEASE USE THE FOLLOWING CODES:

U – UNABLE L – LIMITED P – PAINFUL D – DIFFICULT N – NORMAL H – HAVEN'T TRIED

1. _____LYING ON BACK	5. _____SEXUAL ACTIVITY	9. _____BENDING FORWARD/LIFTING	13. _____DRESSING SELF
2. _____LYING ON SIDES	6. _____GETTING IN / OUT OF CAR	10. _____PROLONGED STANDING	14. _____WALKING
3. _____LYING ON STOMACH	7. _____PUSHING / PULLING	11. _____USING A COMPUTER	15. _____COUGH / SNEEZE/ GRUNT
4. _____TURNING OVER IN BED	8. _____UP/DOWN STAIRS	12. _____SITTING/DRIVING/RIDING	16. _____

UPDATED PATIENT BACKGROUND INFORMATION

YES NO

☐ ☐ **PAST MEDICAL HISTORY** (NEW CONDITIONS, INJURIES, MEDICATIONS)? IF SO, WHAT? _____

☐ ☐ **SOCIAL HISTORY** (START/STOP SMOKING, DRINKING, CAFFEINE, HOBBIES, EXERCISE, ETC)? IF SO, WHAT? _____

☐ ☐ **WORK HISTORY** (NEW JOB/HOURS/RESPONSIBILITIES)? IF SO, WHAT? _____

☐ ☐ **FAMILY HEALTH HISTORY** (NEW CONDITIONS/HEALTH STATUS)? IF SO, WHAT? _____

☐ ☐ **HAS THERE BEEN ANY CHANGES TO YOUR BODY SYSTEMS** (EYES, EARS, CARDIOVASCULAR, RESPIRATORY, NEUROLOGICAL, ENDOCRINE, GASTRO-INTESTINAL, GENITO-URINARY, MUSCULOSKELETAL, SKIN, OR PSYCHIATRIC)? IF SO, WHAT? _____

☐ ☐ **HAVE YOU ATTEMPTED ANY OTHER SELF-CARE REMEDIES TO ALLEVIATE YOUR CONDITION?** (E.G. MEDICINES, TOPICAL CREAMS, BRACING, ICE/HEAT, STRETCHING, PILLOW CHANGE, SUPPORT BELT, MASSAGE, ETC.) IF SO, WHAT? _____

SELF CARE REVIEW

YES NO

☐ ☐ **ARE YOU PERFORMING ANY HOME EXERCISES, STRETCHES, TRACTION, ETC?**
*IF YES, EXPLAIN:_____ *IS IT HELPING? **YES** OR **NO**

☐ ☐ **ARE YOU USING ANY ICE PACKS, HEATING PADS, OR TOPICAL PAIN RELIEVERS/OINTMENTS AT HOME?**
*IF YES, EXPLAIN:_____ *IS IT HELPING? **YES** OR **NO**

☐ ☐ **ARE YOU USING ANY SYMPTOM RELIEVING MEDICATIONS OR VITAMINS/SUPPLEMENTS?**
*IF YES, EXPLAIN:_____ *IS IT HELPING? **YES** OR **NO**

☐ ☐ **ARE YOU USING ANY OTHER SELF CARE REMEDIES IN THE HOME OR OUTSIDE?**
*IF YES, EXPLAIN:_____ *IS IT HELPING? **YES** OR **NO**

NECK & HEADACHE QUESTIONS

WHDF DO YOU GET PAIN OR CRACKING IN THE JAW? **YES** OR **NO**

FREQUENCY OF HEADACHES: _____ PER _____

LOW BACK QUESTIONS

DOES PAIN RADIATE TO THE ABDOMEN AND/OR THE GROIN? **YES** OR **NO**

ANY IMPAIRMENT OF BOWEL OR BALDDER FUNCTION? **YES** OR **NO**

PLEASE PROVIDE:

DOCTOR WILL GATHER:

TEMP:_____ **RESP:**_____

HEIGHT:__ _____ **WEIGHT:**_____

PULSE:_____ **BLOOD PRESSURE** ___ ___/_____ **SIT/STAND**

NOTES:

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARDIAN SIGNATURE: _____ **DATE:** _____

D.C. SIGNATURE: _____ **DATE:** _____