SALUS
CHIROPRACTIC

Re-Activation Form (page 1 of 2)

Name _____ Date _____

If your address changed since your last visit, please update it here:
Address _____ City, State, Zip _____

Check any and all insurance coverage that may be applicable:
☐ Major Medical ☐ Medicaid ☐ Medicare ☐ Auto Accident ☐ Workers Compensation
☐ Medical Savings Account & Flex Plans ☐ Self-pay ☐ Other _____
Please provide us with your insurance card if it changed since your last appointment.

CURRENT HEALTH CONDITION

Briefly tell us the reason for your visit today *(low back pain, neck pain, etc.):* _____

_____

Pain or or problem started on _____
How would you describe your pain? *(check all that apply)*
☐ Dull ☐ Sharp ☐ Tightness ☐ Shooting ☐ Tingling ☐ Numbness ☐ Diffuse ☐ Aching
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is the condition worse during certain parts of the day? _____
Have you seen any other medical provider for this condition? _____

OTHER SYMPTOMS

☐ Headaches	☐ Neck pain	☐ Sleeping problems	☐ Back pain
☐ Nervousness	☐ Tension	☐ Irritability	☐ Chest pains
☐ Dizziness	☐ Face flushed	☐ Neck stiff	☐ Pins & needles in legs
☐ Pins & needles in arms	☐ Numbness in fingers	☐ Numbness in toes	☐ Shortness of breath
☐ Fatigue	☐ Depression	☐ Light bothers eyes	☐ Loss of memory
☐ Ears ring	☐ Fever	☐ Fainting	☐ Buzzing in ear
☐ Loss of smell	☐ Loss of taste	☐ Diarrhea	☐ Feet cold
☐ Hands cold	☐ Stomach upset	☐ Constipation	☐ Loss of balance

☐ Other _____

When was your last adjustment? _____

As a result of my chiropractic care, I would like to (check all that apply)

☐ Feel better quickly
☐ Have a healthier body by keeping my nerve system healthy
☐ Have a healthier spine
☐ Live a healthier lifestyle

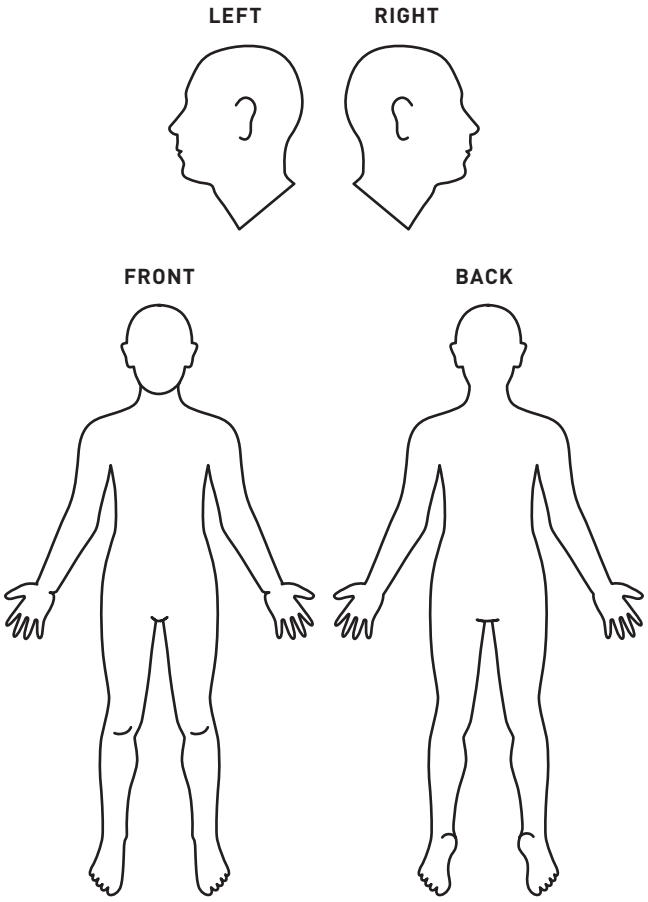
CONTINUED ON BACK

Re-Activation Form (page 2 of 2)

SUBJECTIVE PAIN ASSESSMENT

Place an "X" on the drawings to the right wherever you have pain. Beside the "X" indicate type of pain you are experiencing *(example: XST between your shoulders means you have stabbing pain between your shoulders)*.

A = ACHE
B = BURNING
ST = STABBING
SP = SPASM
N = NUMBNESS
P = PINS AND NEEDLES
T = THROBBING



PAIN SCALE

Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10
NONE		LITTLE			MEDIUM				SEVERE	

Patient's Signature _____ Date: _____

For Doctor's Use Only

☐ Initial Examination ☐ Re-evaluation ☐ New Condition

POSTURAL ANALYSIS

☐ AHT

C: ☐ LR ☐ RR
☐ LF ☐ RF
☐ LT ☐ RT

T: ☐ LF ☐ RF

RANGE OF MOTION

☐ Decrease

CR: ☐ L w/P! ☐ R w/P!
CF: ☐ L w/P! ☐ R w/P!
☐ CF w/P! ☐ CE w/P!

☐ LF w/P! ☐ LE w/P!

Doctor's Signature _____ Date: _____

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