Re-Exam Form

Name: **Date:**

Primary Complaint: (Neck, low back, hip, etc.)

Date of Onset:

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing

Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant (100%-75%) Frequent (75%-50%) Intermittent (50%-25%) Occasional (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)

1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)

Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)

Rest Chiropractic Care Medication Movement Ice Heat

Secondary Complaint:

Date of Onset:

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing

Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant (100%-75%) Frequent (75%-50%) Intermittent (50%-25%) Occasional (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)

1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)

Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)

Rest Chiropractic Care Medication Movement Ice Heat

Tertiary Complaint:

Date of Onset:

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing

Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant (100%-75%) Frequent (75%-50%) Intermittent (50%-25%) Occasional (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)

1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)

Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)

Rest Chiropractic Care Medication Movement Ice Heat

Other:

Date of Onset:

-Type of discomfort: (Circle all that apply) Sharp Dull Aching Burning Numbing

Shooting Tightness Throbbing Diffuse Tingling

-Frequency of discomfort: Constant (100%-75%) Frequent (75%-50%) Intermittent (50%-25%) Occasional (25%-1%)

-Intensity of discomfort: (1= least severe, 10= most severe)

1 2 3 4 5 6 7 8 9 10

-Discomfort increases with: (Circle all that apply if applicable)

Movement Applied Pressure Prolonged Sitting Coughing/Sneezing

-Discomfort decreases with: (Circle all that apply if applicable)

Rest Chiropractic Care Medication Movement Ice Heat

Injuries, Accidents & Surgeries in last year: