

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_  
Incident: \_\_\_\_\_ [office use only]

**RE-EVALUATION**  
**CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS**

**Please use the attached pain drawing to mark the area of your primary complaint.**

**Chief Complaint**

What is your primary complaint in what location? \_\_\_\_\_

Date the symptom first appeared? \_\_\_\_\_

What percentage of your original symptoms do you still have? Choose one:

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Since your last examination, have you had any re-injuries or new injuries? \_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_

**Quality**

**Pain Quality Scale**

Type of pain (check all that apply):

none aching burning constant cramping dull stiffness intermittent mild  
moderate persistent severe sharp shooting stabbing swelling throbbing  
numbness tingling other \_\_\_\_\_

Does the pain travel or radiate? Into arm R or L Into leg R or L Other \_\_\_\_\_

Rate the level of your pain/symptoms from 0, no pain/no symptoms, to 10, unbearable pain/symptoms:

Circle one: 0 1 2 3 4 5 6 7 8 9 10

**Severity**

How frequent is this condition?

acute chronic dull frequent improved improving increased increasing  
infrequent mild moderate w/movement never occasional persistent severe  
stabbing

**Timing**

What makes the condition better? \_\_\_\_\_

What makes the condition worse? \_\_\_\_\_

**Pain:** When do you experience the pain?

in morning end of day later in the day at night various times

**Symptoms:** How did the condition begin?

Gradually Suddenly Progressively over time

**Context**

Explain why or how the condition began: \_\_\_\_\_

**Condition interferes:**

What does this condition prevent you from doing? \_\_\_\_\_

**Modifying Factors:**

For this condition, I have been:

Never been treated Hospitalized Treated by another chiropractor Treated by another provider

**Associated Symptoms**

Are there any other conditions or symptoms that may be related to your major complaint?

No Yes If yes, please explain \_\_\_\_\_

Are there any other unrelated health problems or symptoms?

No Yes If yes, please explain \_\_\_\_\_

# Medical Symptoms Questionnaire

Patient Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point scale      0 – *Never or almost never* have the symptoms  
 1 – *Occasionally* have it, effect is *not severe*  
 2 – *Occasionally* have it, effect is *severe*  
 3 – *Frequently* have it, effect is *not severe*  
 4 – *Frequently* have it, effect is *severe*

**Head**    \_\_\_\_\_ Headaches  
           \_\_\_\_\_ Faintness  
           \_\_\_\_\_ Dizziness  
           \_\_\_\_\_ Insomnia  
           \_\_\_\_\_ **Total**

**Eyes**    \_\_\_\_\_ Watery or itchy eyes  
           \_\_\_\_\_ Swollen, reddened, or sticky eyelids  
           \_\_\_\_\_ Bags or dark circles under eyes  
           \_\_\_\_\_ Blurred or tunnel vision  
                   (do not include near- or far-sightedness)  
           \_\_\_\_\_ **Total**

**Ears**    \_\_\_\_\_ Itchy Ears  
           \_\_\_\_\_ Earaches, ear infection  
           \_\_\_\_\_ Drainage from ear  
           \_\_\_\_\_ Ringing in ears, hearing loss  
           \_\_\_\_\_ **Total**

**Nose**    \_\_\_\_\_ Stuffy Nose  
           \_\_\_\_\_ Sinus Problems  
           \_\_\_\_\_ Hay Fever  
           \_\_\_\_\_ Sneezing attacks  
           \_\_\_\_\_ Excessive mucus formation  
           \_\_\_\_\_ **Total**

**Mouth/Throat**    \_\_\_\_\_ Chronic coughing  
                           \_\_\_\_\_ Gagging, frequent need to clear throat  
                           \_\_\_\_\_ Sore throat, hoarseness, loss of voice  
                           \_\_\_\_\_ Swollen or discolored tongue, gums, lips  
                           \_\_\_\_\_ Canker sores  
                           \_\_\_\_\_ **Total**

**Skin**    \_\_\_\_\_ Acne  
           \_\_\_\_\_ Hives, rashes, dry skin  
           \_\_\_\_\_ Hair loss  
           \_\_\_\_\_ Flushing, hot flashes  
           \_\_\_\_\_ Excessive sweating  
           \_\_\_\_\_ **Total**

**Heart**    \_\_\_\_\_ Irregular or skipped heartbeat  
           \_\_\_\_\_ Rapid or pounding heartbeat  
           \_\_\_\_\_ Chest pain  
           \_\_\_\_\_ **Total**

**Lungs**    \_\_\_\_\_ Chest congestion  
           \_\_\_\_\_ Asthma, bronchitis  
           \_\_\_\_\_ Shortness of breath  
           \_\_\_\_\_ **Total**

**Digestive Tract**    \_\_\_\_\_ Nausea, vomiting  
                           \_\_\_\_\_ Diarrhea  
                           \_\_\_\_\_ Constipation  
                           \_\_\_\_\_ Bloating feeling  
                           \_\_\_\_\_ Belching, passing gas  
                           \_\_\_\_\_ Heartburn  
                           \_\_\_\_\_ Intestinal/stomach pain  
                           \_\_\_\_\_ **Total**

**Joints/Muscle**    \_\_\_\_\_ Pain or aches in joints  
                           \_\_\_\_\_ Arthritis  
                           \_\_\_\_\_ Stiffness or limitation of movement  
                           \_\_\_\_\_ Pain or aches in muscles  
                           \_\_\_\_\_ Feeling of weakness or tiredness  
                           \_\_\_\_\_ **Total**

**Weight**            \_\_\_\_\_ Binge eating/drinking  
                           \_\_\_\_\_ Craving certain foods  
                           \_\_\_\_\_ Excessive weight  
                           \_\_\_\_\_ Compulsive eating  
                           \_\_\_\_\_ Water retention  
                           \_\_\_\_\_ Underweight  
                           \_\_\_\_\_ **Total**

**Energy/Activity**    \_\_\_\_\_ Fatigue, sluggishness  
                           \_\_\_\_\_ Apathy, lethargy  
                           \_\_\_\_\_ Hyperactivity  
                           \_\_\_\_\_ Restlessness  
                           \_\_\_\_\_ **Total**

**Mind**              \_\_\_\_\_ Poor memory  
                           \_\_\_\_\_ Confusion, poor comprehension  
                           \_\_\_\_\_ Poor concentration  
                           \_\_\_\_\_ Poor physical coordination  
                           \_\_\_\_\_ Difficulty in making decisions  
                           \_\_\_\_\_ Stuttering or stammering  
                           \_\_\_\_\_ Slurred speech  
                           \_\_\_\_\_ Learning disabilities  
                           \_\_\_\_\_ **Total**

**Emotions**        \_\_\_\_\_ Mood swings  
                           \_\_\_\_\_ Anxiety, fear, nervousness  
                           \_\_\_\_\_ Anger, irritability, aggressiveness  
                           \_\_\_\_\_ Depression  
                           \_\_\_\_\_ **Total**

**Other**              \_\_\_\_\_ Frequent illness  
                           \_\_\_\_\_ Frequent or urgent urination  
                           \_\_\_\_\_ Genital itch or discharge  
                           \_\_\_\_\_ **Total**

\_\_\_\_\_ **GRAND TOTAL**

# PAIN DRAWING

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date symptoms began and/or date of injury: \_\_\_\_\_

1. Please mark **area(s)** of injury or discomfort using the following symbols:

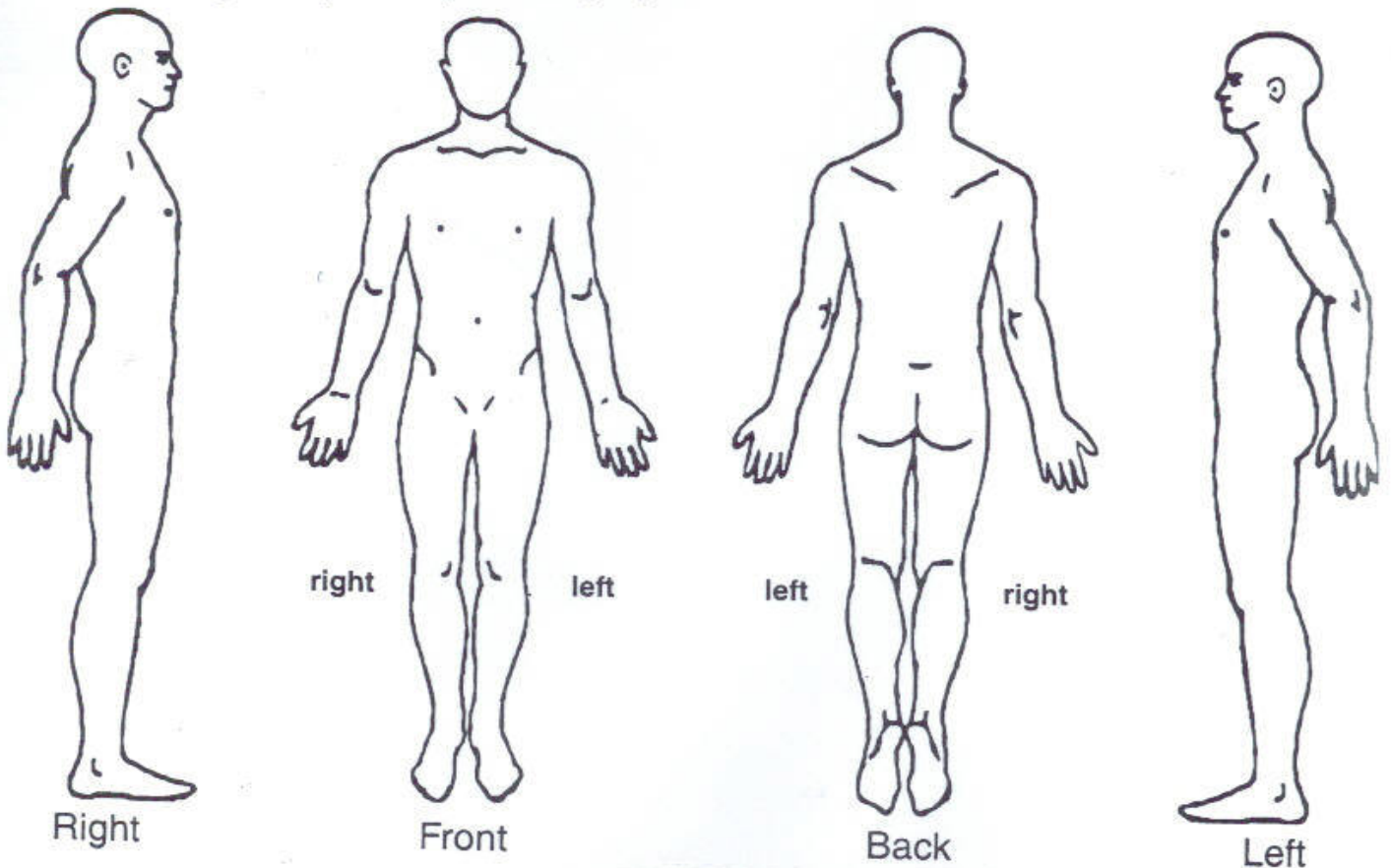
**Type of pain:**

Ache   Dull   Stiffness   Sharp   Stabbing   Shooting   Swelling   Cramping  
 A   D   S   SH   ST   SS   SW   C

Burning   Throbbing   Numbness   Tingling   Other \_\_\_\_\_  
 B   TH   N   T

2. Indicate all scars from surgery or injury using the following symbol: †

3. Circle any area of pain not represented by a symbol.



On a scale of 0-10, please circle the level that most accurately represents your pain.

0 = No pain      10 = Unbearable Pain

|              |   |   |   |   |   |   |   |   |   |   |    |
|--------------|---|---|---|---|---|---|---|---|---|---|----|
| Right Now    | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Average Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At Best      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At Worst     | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |