southcare
Chiropractic & Massage

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## Patient Re-Exam

Patient Name: _____ Date (MM/DD/YYYY) _____

What health issues have brought you in here today?

Wellness Consult ____ Spinal Check-up ____ Back Pain ____ Headache ____Other _____

Auto/Work Accident? ICBC ____ WCB ____ Claim# _____ Date of Accident _____

If you are experiencing pain, is it: Sharp ____ Dull ____ Constant ____ Intermittent ____ Radiating ____

Did it occur: Suddenly ____ Gradually ____

Since the problem started, is it: About the same: ____ Getting Worse ____

What makes it worse: _____

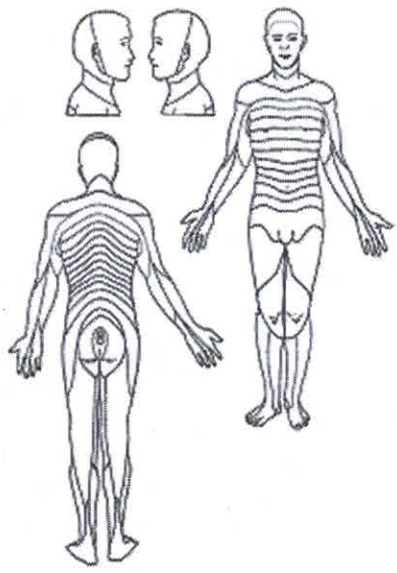
Chief Complaint/Regions of Pain
1)_____
2)_____
3)_____
Circle severity of pain for each region
(1=least, 10= greatest)

Neck ----------
1 2 3 4 5 6 7 8 9 10
Mid Back ----------
1 2 3 4 5 6 7 8 9 10
Low Back ----------
1 2 3 4 5 6 7 8 9 10
Hips ----------
1 2 3 4 5 6 7 8 9 10
Arms ----------
1 2 3 4 5 6 7 8 9 10
Legs ----------
1 2 3 4 5 6 7 8 9 10

Pain Diagram Instructions:

On the following diagrams, indicate all areas of:

| | |
|---|---|
| Ache | ^^^^^^^^ |
| Burning | + + + + + |
| Numbness | OOOOO |
| Pins and Needles | ..... |
| Stabbing | /////////// |
| Stiffness | = = = = = |
| Other (specify) | XXXXXX |



History:

Chiropractic Notes:

DDX: