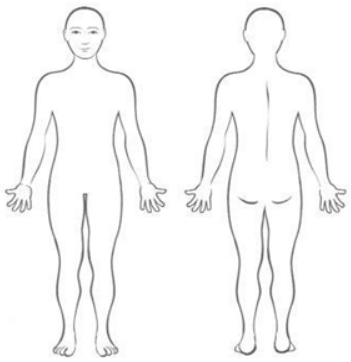
CHICAGO CHIROPRACTIC & SPORTS MEDICINE

Patient Re-exam Self-Assessment Form

Patients Name: _____Date of Service: _____ **Akin**

Chief Complaint(s), please list the top 3 in order of severity, and mark the diagram with an X in all locations where you have pain, numbness, or tingling.



1)_____

2)_____

3)_____

Date symptoms appeared: ___/___/_____

COMPLAINT #1: Pain intensity (0=None, 10=Severe)**:**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Type of Pain:

☐ Stiffness ☐ Swelling ☐ Throbbing ☐ Numbness ☐ Dull ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Sharp ☐ Other: _____

Symptom frequency:

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (1-25%)

COMPLAINT #2 Pain intensity (0=None, 10=Severe)**:**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Type of Pain:

☐ Stiffness ☐ Swelling ☐ Throbbing ☐ Numbness ☐ Dull ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Sharp ☐ Other: _____

Symptom frequency:

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (1-25%)

COMPLAINT #3 Pain intensity (0=None, 10=Severe)**:**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Type of Pain:

☐ Stiffness ☐ Swelling ☐ Throbbing ☐ Numbness ☐ Dull ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling

☐ Cramps ☐ Sharp ☐ Other: _____

Symptom frequency:

☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (1-25%)

Has there been any change in your overall health since your last visit? ☐ Yes ☐ No **If yes, please explain**:

_____

Has there been any change in medications/supplements since the last visit? ☐ Yes ☐ No **If yes, please explain:**_____

Patient Signature: _____ Date: _____