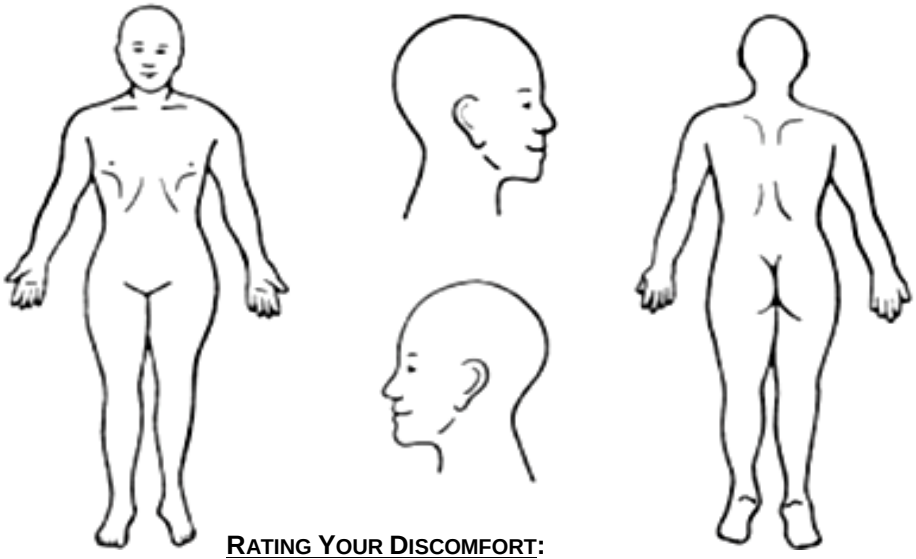
Van Roo
FAMILY CHIROPRACTIC

RE-EXAMINATION & UPDATED HEALTH HISTORY

NAME:_____ DATE:_____

UPDATED HISTORY OF PRESENT ILLNESS / INJURY

X X X BURNING PAIN
((((ACHING PAIN
0 0 0 PINS & NEEDLES
- - - - NUMBNESS
: : : : SHARP PAIN



PLEASE COMPLETE:

_____ CONSTANT
_____ COME & GO

_____ GETTING BETTER
_____ GETTING WORSE
_____ STAYING SAME

BETTER:		WORSE:
_____	AM	_____
_____	MID-DAY	_____
_____	PM	_____

RATING YOUR DISCOMFORT:

ENTER THE NUMBER THAT BEST REPRESENTS YOUR LEVEL OF DISCOMFORT AS IT APPLIES TO YOU. **"0" IS NO DISCOMFORT, "100" IS THE MOST SEVERE.**

NECK (0= NO PAIN):	**MID BACK** (0= NO PAIN):	**LOW BACK** (0= NO PAIN):	_____:	_____:
NOW: _____/100	NOW: _____/100	NOW: _____/100	NOW: _____/100	NOW: _____/100
BEST: _____/100	BEST: _____/100	BEST: _____/100	BEST: _____/100	BEST: _____/100
WORST: _____/100	WORST: _____/100	WORST: _____/100	WORST: _____/100	WORST: _____/100
USUAL: _____/100	USUAL: _____/100	USUAL: _____/100	USUAL: _____/100	USUAL: _____/100

WHAT MAKES THE CONDITION BETTER?

HEAD / NECK _____
MID BACK _____
LOW BACK _____
SHOULDER, ARM, HAND _____
HIP, LEG, FOOT _____
OTHER _____

WHAT MAKES THE CONDITION WORSE?

HEAD / NECK _____
MID BACK _____
LOW BACK _____
SHOULDER, ARM, HAND _____
HIP, LEG, FOOT _____
OTHER _____

ACTIVITIES OF DAILY LIVING

INDICATE YOUR ABILITY TO PERFORM THE FOLLOWING ACTIVITIES. PLEASE USE THE FOLLOWING CODES:

U – UNABLE L – LIMITED P – PAINFUL D – DIFFICULT N – NORMAL H – HAVEN'T TRIED

1. _____ LYING ON BACK
2. _____ LYING ON SIDES
3. _____ LYING ON STOMACH
4. _____ TURNING OVER IN BED
5. _____ SEXUAL ACTIVITY
6. _____ GETTING IN / OUT OF CAR
7. _____ PUSHING / PULLING
8. _____ GOING UP/DOWN STAIRS
9. _____ BENDING FORWARD/LIFTING
10. _____ PROLONGED STANDING
11. _____ USING A COMPUTER
12. _____ SITTING/DRIVING/RIDING
13. _____ DRESSING SELF
14. _____ WALKING
15. _____ COUGH / SNEEZE/ GRUNT
16. _____

NECK/BACK BOURNEMOUTH QUESTIONNAIRE

OVER THE PAST WEEK, ON AVERAGE, HOW WOULD YOU RATE YOUR PAIN? (0–NO PAIN, 10–WORST POSSIBLE PAIN) **/10**

OVER THE PAST WEEK, HOW MUCH HAS YOUR PAIN INTERFERED WITH YOUR DAILY ACTIVITIES (HOUSEWORK, DRESSING, LIFTING, DRIVING, ETC.)? (0 – NO INTERFERENCE, 10 – UNABLE TO PERFORM) **/10**

OVER THE PAST WEEK, HOW MUCH HAS YOUR PAIN INTERFERED WITH YOUR ABILITY TO TAKE PART IN RECREATIONAL, SOCIAL, & FAMILY ACTIVITIES? (0 – NO INTERFERENCE, 10 – UNABLE TO PERFORM) **/10**

OVER THE PAST WEEK, HOW ANXIOUS (TENSE, UPTIGHT, IRRITABLE, DIFFICULTY IN CONCENTRATING OR RELAXING) HAVE YOU BEEN FEELING? (0 – NOT AT ALL ANXIOUS, 10 – EXTREMELY ANXIOUS) **/10**

OVER THE PAST WEEK, HOW DEPRESSED (DOWN-IN-THE-DUMPS, SAD, IN LOW SPIRITS, PESSIMISTIC, UNHAPPY) HAVE YOU BEEN FEELING? (0 – NOT AT ALL DEPRESSED, 10 – EXTREMELY DEPRESSED) **/10**

OVER THE PAST WEEK, HOW HAVE YOU FELT YOUR WORK (BOTH INSIDE AND OUTSIDE THE HOME) HAS AFFECTED (OR WOULD AFFECT) YOUR PAIN? (0 – HAVE MADE IT NO WORSE, 10 – HAVE MADE IT MUCH WORSE) **/10**

OVER THE PAST WEEK, HOW MUCH HAVE YOU BEEN ABLE TO CONTROL (REDUCE/HELP) YOUR PAIN ON YOUR OWN? (0 – COMPLETELY CONTROLLED, 10 – NO CONTROL WHATSOEVER) **/10**

TOTAL POINTS: /70 **TOTAL: %**

SELF CARE REVIEW

YES NO

☐ ☐ **ARE YOU PERFORMING ANY HOME EXERCISES, STRETCHES, TRACTION, ETC.?**
*IF YES, EXPLAIN: _____ *IS IT HELPING? **YES** OR **NO**

☐ ☐ **ARE YOU USING ANY ICE PACKS, HEATING PADS, OR TOPICAL PAIN RELIEVERS/OINTMENTS AT HOME?**
*IF YES, EXPLAIN: _____ *IS IT HELPING? **YES** OR **NO**

☐ ☐ **ARE YOU USING ANY SYMPTOM RELIEVING MEDICATIONS OR VITAMINS/SUPPLEMENTS?**
*IF YES, EXPLAIN: _____ *IS IT HELPING? **YES** OR **NO**

☐ ☐ **ARE YOU USING ANY OTHER SELF CARE REMEDIES EITHER IN THE HOME OR OUTSIDE?**
*IF YES, EXPLAIN: _____ *IS IT HELPING? YES OR NO

TREATMENT OPTIONS

PLEASE SELECT ONE:

☐ I FEEL THAT I'M PAIN-FREE, BACK TO PRE-INJURY STATUS, AND READY TO BE RELEASED.
☐ I FEEL SIGNIFICANTLY BETTER, THOUGH WISH TO CONTINUE WITH MAINTENANCE/WELLNESS CARE.
☐ I FEEL AS THOUGH I AM MUCH BETTER, BUT I KNOW I STILL HAVE SOME HEALING TO DO.
☐ I FEEL AS THOUGH I AM SOME BETTER AND UNDERSTAND I HAVE A WAYS TO GO.
☐ I AM FRUSTRATED WITH MY PROGRESS AND WISH TO DISCUSS MY OPTIONS.

NOTES:

Please Provide:

Height: _____ Weight:_____

Doctor Will Gather: Temp: _____ Resp: _____

Pulse:_____ Blood Pressure: _____/_____ Sit/Stand

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARDIAN SIGNATURE: _____ **DATE:** _____

D.C. SIGNATURE: _____ **DATE:** _____