

**Blackman Chiropractic Center
Re-Examination**

Name _____ Signature _____ Date _____

What are your goals for achieving better health? _____

Present Symptoms: please explain any symptoms you are having.

Head _____
 Neck _____
 Mid Back _____
 Shoulders _____
 Arms _____
 Hands _____
 Low Back _____
 Hips _____
 Legs _____
 Feet _____
 Digestive _____

How have your symptoms changed from when you first came in? _____

Nervous System Complaints

_____ Headache	_____ Difficulty Sleeping	_____ Dizziness
_____ Blurred Vision	_____ Loss of Energy	_____ Ringing in Ears
_____ Memory Loss		

Recent treatments for this condition outside of this office? If yes, list dates, treatments, and healthcare provider _____

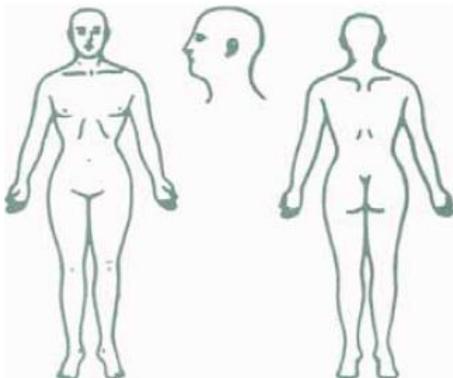
Recent falls/accidents? If yes, explain _____

What activities make you feel BETTER: _____
 WORSE: _____

Symptoms are Better _____ AM _____ Midday _____ PM On a scale on 1- 10, 10 being the worst, how
 Symptoms are Worse _____ AM _____ Midday _____ PM would you rate your pain? _____

Please shade and code affected areas:
 P=Pain N=Numbness S=Spasm T=Tenderness

Indicate ability to perform the following activities
 U=Unable P=Painful D=Difficult L=Limited N=Normal



- | | |
|--------------------------------------|-----------------------|
| _____ Coughing/Sneezing | _____ Climbing |
| _____ Getting in/out of car | _____ Kneeling |
| _____ Bending forward to brush teeth | _____ Balancing |
| _____ Turning over in bed | _____ Dressing |
| _____ Walking short distances | _____ Sleeping |
| _____ Standing for more than 1 hour | _____ Stooping |
| _____ Sitting at a table/desk | _____ Gripping |
| _____ Lying on back | _____ Pushing |
| _____ Lying on stomach | _____ Reaching |
| _____ Lying on side with knees bent | _____ Sexual Activity |
| _____ Bending forward | |