symmes Chiropractic Center

PATIENT FOLLOW-UP

To monitor your progress, please answer the questions below. These correspond to questions asked on your first visit to this office.

Patient Name: _____ File: _____

Describe the status of your original complaints: _____

_____

_____

Since your treatment began, your symptoms are: Decreasing Not Changing Increasing
Since your treatment began, your overall function is: Improving Not Changing Worsening

Have you, during your course of treatment, done anything to make your complaints worse? NO YES

If YES, please explain: _____

Any new complaints? NO YES Describe: _____

_____

Please describe the character of your current symptoms (YOU MAY CHECK ONE OR MORE ANSWERS):
Dull Sore/Ache Sharp Stabbing Burning Tingling Numbness Shooting/Radiating
Weak Tension Spasm Throbbing Restricted Movement

Indicate the intensity of your symptoms on their average: (CIRCLE ONE NUMBER)
Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Symptoms are **better** in: Morning Afternoon Evening No Change with Time of Day
Symptoms are **worse** in: Morning Afternoon Evening No Change with Time of Day

How often are the symptoms present?
Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

What makes your problem **better**?
Nothing Lying Down Sitting Standing Walking Lifting Carrying Pushing Pulling
Movement Exercise Inactivity Sleep Stretching Hot Water Weather Other _____

What makes your problem **worse**?
Nothing Lying Down Sitting Standing Walking Lifting Carrying Pushing Pulling
Movement Exercise Inactivity Sleep Stretching Hot Water Weather Other _____

Are you currently receiving other therapy/treatment? NO YES, please describe: _____

How would you grade your general stress level? No Stress Minimal Stress Moderate Stress Greatly Stressed

Physical activity at work: Sitting >50% of workday Light Manual Labor Manual Labor Heavy Manual Labor

General physical activity: No Regular Exercise Light Exercise Strenuous Exercise

Any changes with your Diet Vitamin/Herb Supplements Medication/s? NO YES
If YES, please describe: _____

Has your weight recently changed by more than 10 pounds? No Gain Loss

Rate your overall satisfaction with the treatment received to date? Very Pleased Pleased Somewhat Lacking

Patient Signature: _____ Date: _____