

CONFIDENTIAL

Update Evaluation - Progress Assessment

Patient Name: _____ Intern: _____

1. What was your original chief complaint(s)? (low back pain, neck pain, etc)

2. How do you rate your overall improvement since beginning care?

Excellent: _____ Good: _____ Fair: _____ Poor: _____

3. What symptoms have improved?

4. What symptoms do you still have?

5. Do you have any new complaints? If yes, please explain:

6. What changes have you noticed in your daily routine?

No change _____

Walking _____ Riding _____ Working _____ Bending _____

Standing _____ Sitting _____ Lifting _____ Reading _____

7. Do you have any questions regarding your progress or care?

Patient's Signature: _____

Date: _____

Health History

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Patient Name: _____ Intern: _____

1. Please mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected area(s).

Numbness ////	
Pins and Needles OOOO	
Burning xxx	
Stabbing sss	
Ache ^^^	

2. How bad is your pain now? Please write in the names of the problem area, from least to worst over the corresponding number that you want to circle. Repeat this for each of the four parts below; your pain level right now, average pain and the pain at it's best and worst. **HERE IS AN EXAMPLE:**

No Pain	<i>Low Back Pain</i>	Worst Possible Pain								
0	1	2	3	4	5	6	7	8	9	10

A. What is your pain RIGHT NOW?

No Pain		Worst Possible Pain								
0	1	2	3	4	5	6	7	8	9	10

B. What is your AVERAGE pain level?

No Pain		Worst Possible Pain								
0	1	2	3	4	5	6	7	8	9	10

C. What is your pain level when it's at its BEST?

No Pain		Worst Possible Pain								
0	1	2	3	4	5	6	7	8	9	10

D. What is your pain when it's at its WORST?

No Pain		Worst Possible Pain								
0	1	2	3	4	5	6	7	8	9	10

Patient's Signature: _____ Date: _____

Please perform the following, **circled**, outcome assessment(s):
 HDI NDI OLBQ UE LE Zung None

Clinician's Signature: _____ Date: _____

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Patient Name: _____ Intern: _____

Past Medical History:

1. Have you been hospitalized or had any surgeries? Yes _____ No _____

If yes, when did it take place, for what condition, and what was the result? _____

2. Have you had any trauma or been involved in any accidents (*work, car, falls, etc.*)? Yes _____ No _____

If yes, what type of trauma/accident, were you injured and what type of care did you receive? _____

3. Have you been diagnosed with any childhood illness(es) (*Measles, Chickenpox, Mumps, Scarlet Fever, Rheumatic Fever, Diabetes, Cancer, Birth Defects, etc.*)? Yes _____ No _____

If yes, which illness(es)? _____

4. Have you been diagnosed with any illness(es) as an adult (*Shingles, Diabetes, Cancer, High Blood Pressure, etc.*)? Yes _____ No _____

If yes, which illness(es)? _____

5. Are you taking any medication (prescribed or over the counter), vitamins, or supplements? Yes _____ No _____

If yes, which type and for what condition? _____

6. Please list all the different doctors and their specialties, including chiropractors, you have seen in the last 3 years.

Date Doctor Reason

Health History

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Patient Name: _____ Intern: _____

Family History:

1. Has anyone in your family (*Grandparents, Parents, Siblings*) been diagnosed with an illness (*High Blood Pressure, Heart Trouble, Diabetes, Depression, Arthritis, Cancer, etc*) ?

Yes _____ No _____

If yes, which illness(es) or condition? _____

Social History:

1. Do you drink any alcoholic beverages?

Yes _____ No _____

If yes, what type, how much, and how often? _____

2. Do you smoke? Yes _____ No _____ ppd _____ How long? _____

3. Do you use smokeless tobacco? Yes _____ No _____ How long? _____

4. Have you ever smoked or used tobacco? Yes _____ No _____ How long? _____

5. Are you sexually active? Yes _____ No _____

Protected? Yes _____ No _____

6. Do you currently or have you taken recreational drugs within the last year? Yes _____ No _____

If yes, which drug(s)? _____

Occupational History:

1. Are you currently employed? Yes _____ No _____ FT _____ PT _____

2. If employed, what is your occupation and please describe your work related activities?

Habits:

1. How many hours of sleep do you get each night? _____

2. Do you have trouble falling or staying asleep? Yes _____ No _____

If yes, please describe: _____

3. Do you wear a seatbelt when riding in the car? Yes _____ No _____

4. Do you wear a helmet when riding a bike/motorcycle? Yes _____ No _____ N/A _____

Health History

Physical Activity, Nutrition and Behaviors Monitoring Form

Patient Name: _____ Intern: _____

Please complete the following questionnaire for yourself or your child.

PHYSICAL ACTIVITY/INACTIVITY		
1. ACTIVITY LEVEL – Compared to others of the same age/sex, are you (your child)?	2. EXERCISE DAYS - On how many of the past 7 days did you (your child) exercise or participate in physical activity for at least 20 minutes that made you/your child sweat or breathe hard?	
<input type="checkbox"/> A lot less physically active than most	<input type="checkbox"/> 0 Days	<input type="checkbox"/> 5 Days
<input type="checkbox"/> A little less physically active than most	<input type="checkbox"/> 1 Days	<input type="checkbox"/> 6 Days
<input type="checkbox"/> Average - same as most	<input type="checkbox"/> 2 Days	<input type="checkbox"/> 7 Days
<input type="checkbox"/> A little more physically active than most	<input type="checkbox"/> 3 Days	<input type="checkbox"/> Don't know/not sure
<input type="checkbox"/> A lot more physically active than most	<input type="checkbox"/> 4 Days	
<input type="checkbox"/> Don't know/not sure		
3. TV WEEKDAY - How many hours of television do you (your child) watch on the typical week day?	4. TV WEEKEND - How many hours of television do you (your child) usually watch on the typical weekend day?	
<input type="checkbox"/> None <input type="checkbox"/> 3 hours	<input type="checkbox"/> None	<input type="checkbox"/> 3 hours
<input type="checkbox"/> 6 hours or more <input type="checkbox"/> 2 hours	<input type="checkbox"/> 6 hours or more	<input type="checkbox"/> 2 hours
<input type="checkbox"/> 5 hours <input type="checkbox"/> 1 hour or less	<input type="checkbox"/> 5 hours	<input type="checkbox"/> 1 hour or less
<input type="checkbox"/> 4 hours <input type="checkbox"/> Don't know/not sure	<input type="checkbox"/> 4 hours	<input type="checkbox"/> Don't know/not sure
SWEETENED BEVERAGES		
5. SODA TIMES – On a typical day, how many times do you (your child) drink soda? Do not count 'diet' soda.	6. SWEETENED BEVERAGE TIMES – On a typical day, how many times do you (your child) drink sweetened beverages such as sweet tea, punch, kool aid, sport drinks or fruit drinks? Do not count 100% fruit juices.	7. SODA AMOUNT – How much soda or other sweetened beverage do you (your child) typically drink each time?
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> 1 bottle (16-20 ounces)
<input type="checkbox"/> 3 times or more	<input type="checkbox"/> 3 times or more	<input type="checkbox"/> 1 can (12 ounces)
<input type="checkbox"/> 2 times	<input type="checkbox"/> 2 times	<input type="checkbox"/> Large glass (16-20+ ounces)
<input type="checkbox"/> 1 time	<input type="checkbox"/> 1 time	<input type="checkbox"/> Medium glass (8-12 ounces)
<input type="checkbox"/> Don't know/not sure	<input type="checkbox"/> Don't know/not sure	<input type="checkbox"/> Small glass (4-6 ounces)
		<input type="checkbox"/> Don't drink soft drinks or soda
		<input type="checkbox"/> Don't know/not sure
FAST FOOD FREQUENCY	FAT SNACK INTAKE	
8. FAST FOOD – How many times a week do you (your child) eat food from a fast food restaurant like McDonalds, Burger King, Taco Bell, or Pizza Hut?	9. CHIPS – In a typical week, how many times do you (your child) eat french fries or chips? Chips are potato chips, tortilla chips, corn chips or other snack chips.	
<input type="checkbox"/> More than 5 times per week <input type="checkbox"/> Less than once a week	<input type="checkbox"/> 3 or more times per week <input type="checkbox"/> None	
<input type="checkbox"/> 3 to 5 times a week <input type="checkbox"/> Don't know/not sure	<input type="checkbox"/> 2 times a week <input type="checkbox"/> Don't know/not sure	
<input type="checkbox"/> 2 times a week	<input type="checkbox"/> Once a week	
<input type="checkbox"/> Once a week		
LOW FAT DAIRY INTAKE		
10. MILK AMOUNT – On a typical day, how many glasses of milk do you (your child) drink? (A glass is the amount in a small carton at school or an 8 ounce drinking glass.)	11. Milk Type – What type of milk do you (your child) usually drink?	
<input type="checkbox"/> None <input type="checkbox"/> 3 glasses	<input type="checkbox"/> Flavored (2% or whole) <input type="checkbox"/> Low fat (½ – 1%)	
<input type="checkbox"/> < 1 glass <input type="checkbox"/> 4 or more glasses	<input type="checkbox"/> Whole <input type="checkbox"/> Skim or non-fat	
<input type="checkbox"/> 1 glass <input type="checkbox"/> Lactose intolerant	<input type="checkbox"/> Flavored (low fat or skim) <input type="checkbox"/> Soy milk	
<input type="checkbox"/> 2 glasses <input type="checkbox"/> Don't know/not sure	<input type="checkbox"/> Reduced fat (2%) <input type="checkbox"/> Don't know/not sure	
FRUIT AND VEGETABLE INTAKE		
12. VEGETABLES – On a typical day, how many servings of vegetables do you (your child) eat? Do not include french fries.	13. FRUITS – On a typical day, how many servings of fruit do you (your child) eat?	
<input type="checkbox"/> None <input type="checkbox"/> 3 or more servings	<input type="checkbox"/> None <input type="checkbox"/> 3 or more servings	
<input type="checkbox"/> 1 serving <input type="checkbox"/> Don't know/not sure	<input type="checkbox"/> 1 serving <input type="checkbox"/> Don't know/not sure	
<input type="checkbox"/> 2 servings	<input type="checkbox"/> 2 servings	

Are you currently on any special diet? Yes _____ No _____
 If yes, was it prescribed by a doctor? Yes _____ No _____

Patient's Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____

Health History

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Review of Systems

Patient Name: _____ Intern: _____

<p><u>Skin</u> Y N <input type="checkbox"/> <input type="checkbox"/> Hives, Eczema or rash _____ <input type="checkbox"/> <input type="checkbox"/> Cancer _____ <input type="checkbox"/> <input type="checkbox"/> Unusual spots/moles _____ <input type="checkbox"/> <input type="checkbox"/> Other _____</p> <p><u>Head</u> Y N <input type="checkbox"/> <input type="checkbox"/> History of head injury _____ <input type="checkbox"/> <input type="checkbox"/> Headaches _____ <input type="checkbox"/> <input type="checkbox"/> Dizziness or Lightheadedness _____</p> <p><u>Eyes</u> Y N <input type="checkbox"/> <input type="checkbox"/> Eye pain _____ <input type="checkbox"/> <input type="checkbox"/> Redness, Itchy, Dry _____ <input type="checkbox"/> <input type="checkbox"/> Eye disease or injury _____ <input type="checkbox"/> <input type="checkbox"/> Abnormal vision _____ <input type="checkbox"/> <input type="checkbox"/> Glaucoma or Cataracts _____</p> <p><u>Ears</u> Y N <input type="checkbox"/> <input type="checkbox"/> Ringing in ears _____ <input type="checkbox"/> <input type="checkbox"/> Impaired hearing _____ <input type="checkbox"/> <input type="checkbox"/> Earache _____</p> <p><u>Nose/Throat</u> Y N <input type="checkbox"/> <input type="checkbox"/> Frequent/Recurrent Nose bleeds _____ <input type="checkbox"/> <input type="checkbox"/> Recurrent Sinusitis _____ <input type="checkbox"/> <input type="checkbox"/> Recurrent SoreThroat _____ <input type="checkbox"/> <input type="checkbox"/> Recurrent Hoarse Voice _____</p> <p><u>Mouth</u> Y N <input type="checkbox"/> <input type="checkbox"/> Dental problems _____ <input type="checkbox"/> <input type="checkbox"/> Gum Disease _____ <input type="checkbox"/> <input type="checkbox"/> Sore tongue _____ <input type="checkbox"/> <input type="checkbox"/> Taste changes _____ <input type="checkbox"/> <input type="checkbox"/> Pain in jaw on opening or Chewing _____ <input type="checkbox"/> <input type="checkbox"/> Last Dental Checkup _____</p> <p><u>Neck</u> Y N <input type="checkbox"/> <input type="checkbox"/> Thyroid problems, hypo or hyper _____ <input type="checkbox"/> <input type="checkbox"/> Swollen glands/lumps in neck _____ <input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing _____</p>	<p><u>Musculoskeletal</u> Y N <input type="checkbox"/> <input type="checkbox"/> Arm/Leg pain, pins/needles _____ <input type="checkbox"/> <input type="checkbox"/> Hand/Foot pain, pins/needles _____ <input type="checkbox"/> <input type="checkbox"/> Back Pain _____ <input type="checkbox"/> <input type="checkbox"/> Neck Pain _____ <input type="checkbox"/> <input type="checkbox"/> Diagnosed Arthritis _____</p> <p><u>Respiratory</u> Y N <input type="checkbox"/> <input type="checkbox"/> Chronic colds/flu or cough _____ <input type="checkbox"/> <input type="checkbox"/> Coughing up blood or sputum _____ <input type="checkbox"/> <input type="checkbox"/> Asthma/ Difficulty breathing _____ <input type="checkbox"/> <input type="checkbox"/> History of Lung Disease or COPD _____ <input type="checkbox"/> <input type="checkbox"/> Allergies _____</p> <p><u>Cardiovascular</u> Y N <input type="checkbox"/> <input type="checkbox"/> Chest pain or angina _____ <input type="checkbox"/> <input type="checkbox"/> Shortness of breath with activity _____ <input type="checkbox"/> <input type="checkbox"/> Heart murmur/palpitations _____ <input type="checkbox"/> <input type="checkbox"/> Heart attack _____ <input type="checkbox"/> <input type="checkbox"/> Swelling of hands or feet _____ <input type="checkbox"/> <input type="checkbox"/> High blood pressure _____ <input type="checkbox"/> <input type="checkbox"/> High cholesterol _____ <input type="checkbox"/> <input type="checkbox"/> Leg cramps or varicose veins _____ <input type="checkbox"/> <input type="checkbox"/> Stroke _____</p> <p><u>Genitourinary</u> Y N <input type="checkbox"/> <input type="checkbox"/> Lack of bladder control _____ <input type="checkbox"/> <input type="checkbox"/> Urinary frequency _____ <input type="checkbox"/> <input type="checkbox"/> Night frequency _____ <input type="checkbox"/> <input type="checkbox"/> Difficulty in starting/stopping urination _____ <input type="checkbox"/> <input type="checkbox"/> Burning or painful urination _____ <input type="checkbox"/> <input type="checkbox"/> Chronic bladder infections _____ <input type="checkbox"/> <input type="checkbox"/> Blood in urine _____ <input type="checkbox"/> <input type="checkbox"/> Kidney disease _____ <input type="checkbox"/> <input type="checkbox"/> Kidney stone _____ <input type="checkbox"/> <input type="checkbox"/> STD _____ <input type="checkbox"/> <input type="checkbox"/> Yeast infections _____</p>	<p><u>Gastrointestinal</u> Y N <input type="checkbox"/> <input type="checkbox"/> Ulcers _____ <input type="checkbox"/> <input type="checkbox"/> Eating disorder _____ <input type="checkbox"/> <input type="checkbox"/> Chronic indigestion _____ <input type="checkbox"/> <input type="checkbox"/> Bloating, Cramping, Gas _____ <input type="checkbox"/> <input type="checkbox"/> Irritable bowel _____ <input type="checkbox"/> <input type="checkbox"/> Gall bladder disease _____ <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Cirrhosis _____ <input type="checkbox"/> <input type="checkbox"/> Painful bowel movements _____ <input type="checkbox"/> <input type="checkbox"/> Bloody or Black Stool _____ <input type="checkbox"/> <input type="checkbox"/> Recent change in bowel Habits _____ <input type="checkbox"/> <input type="checkbox"/> Recurrent Constipation or Diarrhea _____ <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids _____ <input type="checkbox"/> <input type="checkbox"/> Hiatal hernia _____ <input type="checkbox"/> <input type="checkbox"/> Nausea or Vomiting _____</p> <p><u>Female Genital/OB History</u> Y N <input type="checkbox"/> <input type="checkbox"/> Are you on birth control _____ <input type="checkbox"/> <input type="checkbox"/> Complications with birth control _____ <input type="checkbox"/> <input type="checkbox"/> Are your periods normal _____ <input type="checkbox"/> <input type="checkbox"/> Premenstrual syndrome _____ <input type="checkbox"/> <input type="checkbox"/> Peri or Post-Menopausal _____ <input type="checkbox"/> <input type="checkbox"/> History of ovarian cysts/fibroid tumors, Endometriosis _____ <input type="checkbox"/> <input type="checkbox"/> Sexual dysfunction _____ <input type="checkbox"/> <input type="checkbox"/> Lumps in breast/discharge _____ <input type="checkbox"/> <input type="checkbox"/> Diagnosed Osteoporosis _____</p> <p>Last menstrual period _____ Last PAP test _____ Results _____ Last mammogram _____ Results _____ Last performed monthly breast exam _____ Number of pregnancies _____ Number of live births _____ Abortions _____ Miscarriages/Still births _____</p>
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