Patient Reassessment Update Form

Name________________________________ Date______________

Address__________________________ City__________ PC__________

Telephone Number_________________ Work Number______________

Birthdate_______________

In order for us to best serve you, we must, naturally, have all available information regarding your present health. To bring our original case history up-to-date would you please provide us with the following health information.

What is your primary concern? _______________

____

How long have you had this condition___________

____

Was the onset □ Gradual □ Sudden

Recent surgery, falls & accidents______________

____

Can you localize the discomfort? _______________

____

Circle one

How would you characterize the discomfort?

Ache dull sharp stabbing cramping tingling burning numbness

How intense is the discomfort?

Least 0 1 2 3 4 5 6 7 8 9 10 most

Rate the order of aggravation

Sit___ Stand___ Walk___

1 best - 3 worst

Medication currently taking____________________

____

Patient's Signature____________________________

Doctor's Comments:

____

____

Date of last examination_____________

Please mark your areas of pain below