Advanced Chiropractic Health Center
Working for your wellness, naturally

Charles W. Chapple, D.C., F.I.C.P.A.
Acupuncture, Applied Kineseology and Chiropractic Pediatric Certified

SUBJECTIVE RE-EVALUATION UPDATE

Please describe your pain; check all appropriate and indicate area.
Example: X Stabbing: neck ; X Numbness: rt. arm, Little finger.

___ Stabbing: ________ ___ Burning: ________ __ Numbness: _______
___ Tender: ________ ___ Pins & Needles _____ __ Aching:__________
___ Throbbing:________ ___ Dull: ____________ __ Itching:__________
___ Partial loss of feeling:___________ ___ Total loss of feeling:_________

FREQUENCY OF PAIN

___ Constant, _____ Always, _______ Most of the Time
___ Intermittent _____ indicate what percent of the time_________%

Please rate your Intensity of pain on a scale of 0-10. **O**(no pain)-- **10**(excruciating).
Note appropriate area, circle appropriate number.

- Area_________ 0,1,2,3,4,5,6,7,8,9,10.
- Area_________ 0,1,2,3,4,5,6,7,8,9,10.
- Area_________ 0,1,2,3,4,5,6,7,8,9,10.

In reference to the following descriptions, check appropriate column as to what activities increase or decrease your symptoms.

	Increase	Decrease
With a cough	_______	_______
Sitting down	_______	_______
Driving an automobile	_______	_______
Bending over to brush teeth	_______	_______
Walking	_______	_______
Lying flat on back	_______	_______
Lying on stomach	_______	_______
Lying on side with knees bent	_______	_______
Upon awakening in morning	_______	_______
At the end of the day	_______	_______
In the middle of the night	_______	_______

Please list any other activities which increase or decrease you symptoms not listed above.____

How do you rate your recovery in a percentage figure. 0-no change from initial visit, and 100-total and complete recovery. _______%

Have you experienced any new complaints or problems since your last examination?____________ If Yes, please describe.

Rate your level of understanding of: **0** (None) to **10** (Full).

Chiropractic	0, 1 , 2 , 3 , 4 , 5 , 6 , 7 , 8 , 9 , 10
Subluxation	0, 1, 2 , 3 , 4 , 5 , 6 , 7, 8 , 9 , 10
Adjustment	0, 1 , 2 , 3, 4 , 5 , 6 , 7 , 8 , 9 ,10
Stabilization	0, 1 , 2 , 3 , 4 , 5 , 6 , 7, 8, 9, 10
Maintenance	0, 1 , 2 , 3 , 4 , 5 , 6 , 7, 8 , 9 , 10
Health	0, 1 , 2 , 3 , 4, 5 , 6 , 7 , 8 , 9 ,10

Date ______________20______ Name________________________

360 E. Irving Park Road · Roselle, Illinois 60172 · (630) 894-8778 · Fax (630) 894-8873