Integrated
Pain Solutions

827 Cormier Road, Green Bay, WI 54304-4706
N2120 County Road S, Antigo, WI 54409

Re-Evaluation/
Re-Exam Form

Please Print

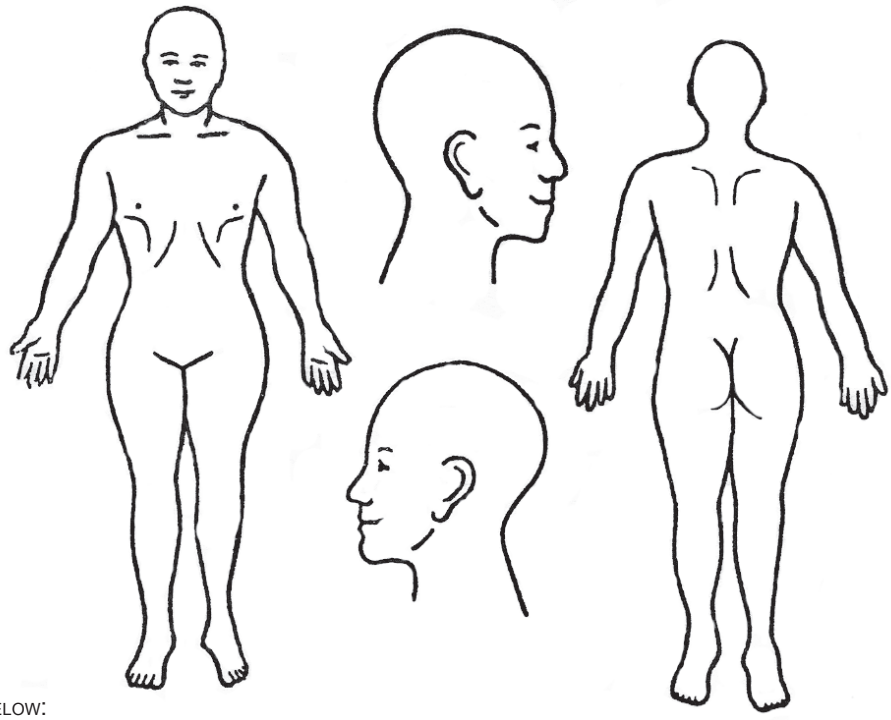
Name: _____ Date: _____

Updated History of Present Illness/Injury

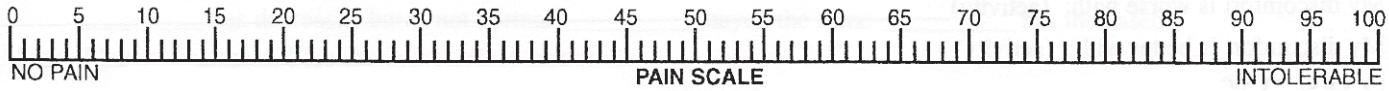
Chief Complaint

Be sure to fill out this section as accurately as possible. Mark the area with the described sensation, using the appropriate symbols.

XXX Burning (BU)
(((Aching Pain (AC)
000 Pins & Needles (PI)
- - - Numbness (NU)
: : : Sharp Pains (SH)



Please rate your pain using the scale below:
If there is more than one area of discomfort, please rate the pain on a scale of 0 to 100 next to each area, with 0 being no pain and 100 being intolerable pain.



Please answer the first four questions below using a pain scale of 0-100 with 0 being no pain and 100 being the worst pain.

1. What is your pain level now? _____
2. What is your pain level most of the time? _____
3. What is your pain level at its best? _____
4. What is your pain level at its worst? _____

5. How often are you at a zero pain level?
   - a. At least once a day
   - b. Once a week
   - c. Once every other week
   - d. Once a month
   - e. More than once a week
   - f. Other _____

☐ Yes ☐ No Does the pain interfere with your sleep? How many times do you wake up? _____
☐ Yes ☐ No Does weather affect your pain? _____

Indicate your ability to perform the following activities. Please use these codes:

U - Unable L - Limited P - Painful D - Difficult N- Normal H - Haven't tried

☐ Lying on back	☐ Gripping	☐ Pushing	☐ Bending forward to brush teeth
☐ Lying on side w/knees bent	☐ Climbing	☐ Kneeling	☐ Standing more than one hour
☐ Turning over in bed	☐ Pulling	☐ Stooping	☐ Balancing
☐ Getting in/out of car	☐ Dressing Self	☐ Sitting at table	☐ Cough/Sneeze/Grunt
☐ Lying flat on stomach	☐ Sexual Activity	☐ Bending forward	How? _____
☐ Reaching	☐ Sleeping	☐ Walking short Distances	Where? _____

- ☐ I STAY AT HOME MOST OF THE TIME BECAUSE OF THE PAIN.
- ☐ I CHANGE POSITION FREQUENTLY TO TRY TO DECREASE MY PAIN.
- ☐ I WALK MORE SLOWLY THAN USUAL BECAUSE OF THE PAIN.
- ☐ BECAUSE OF MY PAIN, I AM NOT DOING ANY JOBS THAT I USUALLY DO AROUND THE HOUSE.
- ☐ BECAUSE OF MY PAIN, I USE A HANDRAIL TO GET UPSTAIRS.
- ☐ BECAUSE OF MY PAIN, I LIE DOWN TO REST MORE OFTEN.
- ☐ BECAUSE OF MY PAIN, I HAVE TO HOLD ON TO SOMETHING TO GET OUT OF AN EASY CHAIR.
- ☐ BECAUSE OF MY PAIN, I TRY TO GET OTHER PEOPLE TO DO THINGS FOR ME.
- ☐ I GET DRESSED MORE SLOWLY THAN USUAL BECAUSE OF MY PAIN.
- ☐ I ONLY STAND UP FOR SHORT PERIODS OF TIME BECAUSE OF MY PAIN.
- ☐ BECAUSE OF THE PAIN, I TRY NOT TO BEND OR KNEEL DOWN.
- ☐ I FIND IT DIFFICULT TO GET OUT OF A CHAIR BECAUSE OF THE PAIN.
- ☐ I HAVE PAIN ALMOST ALL OF THE TIME.
- ☐ I FIND IT DIFFICULT TO TURN OVER IN BED BECAUSE OF THE PAIN.
- ☐ MY APPETITE IS NOT VERY GOOD BECAUSE OF THE PAIN.
- ☐ I HAVE TROUBLE PUTTING ON MY SOCK (STOCKINGS) BECAUSE OF THE PAIN.
- ☐ I CAN ONLY WALK SHORT DISTANCES BECAUSE OF THE PAIN.
- ☐ I SLEEP LESS WELL BECAUSE OF THE PAIN.
- ☐ BECAUSE OF THE PAIN, I GET DRESSED WITH THE HELP OF SOMEONE ELSE.
- ☐ I SIT DOWN FOR MOST OF THE DAY BECAUSE OF THE PAIN.
- ☐ I AVOID HEAVY JOBS AROUND THE HOUSE BECAUSE OF THE PAIN.
- ☐ BECAUSE OF THE PAIN, I AM MORE IRRITABLE AND BAD TEMPERED WITH PEOPLE THAN USUAL.
- ☐ BECAUSE OF THE PAIN, I GO UPSTAIRS MORE SLOWLY THAN USUAL.
- ☐ I STAY IN BED MOST OF THE TIME BECAUSE OF THE PAIN.

☐ **NO CHANGE SINCE LAST EVALUATION**

SOCIAL HEALTH HISTORY UPDATE

WORK HOURS PER WEEK:_____ RECREATIONAL ACTIVITIES (HOBBIES): _____

☐ YES ☐ NO DO YOU COMMUTE TO WORK? HOW FAR? _____

☐ YES ☐ NO DO YOU EXERCISE? TIMES PER _____

☐ YES ☐ NO ARE YOU A SMOKER? PACKS PER DAY? _____

☐ YES ☐ NO DO YOU CONSUME CAFFEINE? HOW MUCH PER DAY? _____

☐ YES ☐ NO DO YOU CONSUME ALCOHOL? GLASSES PER DAY / WEEK? _____

☐ **NO CHANGE SINCE LAST EVALUATION**

HAVE YOU HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES OR N FOR NO IN EACH OF THE FOLLOWING:)

- ☐ EYES
- ☐ EARS, NOSE, MOUTH, THROAT
- ☐ HEART
- ☐ LUNGS/BREATHING
- ☐ INTESTINES
- ☐ URINARY
- ☐ MUSCLES
- ☐ NERVES
- ☐ SKIN
- ☐ PSYCHOLOGICAL
- ☐ INTERNAL ORGANS
- ☐ BLOOD
- ☐ ALLERGIES
- ☐ OTHER _____

SYMPTOMS UPDATE

CHECK SYMPTOMS THAT HAVE BECOME APPARENT:

1. ☐ NERVOUSNESS
2. ☐ NECK PAIN/STIFFNESS
3. ☐ MID BACK PAIN
4. ☐ LOW BACK PAIN
5. ☐ EYES SENSITIVE TO LIGHT
6. ☐ PAIN BEHIND EYES
7. ☐ DIZZINESS
8. ☐ COLD SWEATS
9. ☐ FACE FLUSHED
10. ☐ RINGING/BUZZING EARS
11. ☐ LOSS OF BALANCE
12. ☐ LOSS OF SMELL
13. ☐ LOSS OF TASTE
14. ☐ LOSS OF MEMORY
15. ☐ PINS & NEEDLES - ARMS
16. ☐ PINS & NEEDLES - LEGS
17. ☐ SHORTNESS OF BREATH
18. ☐ HEAD SEEMS TOO HEAVY
19. ☐ IRRITABILITY
20. ☐ DEPRESSION
21. ☐ SLEEPING TROUBLE
22. ☐ TOE NUMBNESS
23. ☐ FINGER NUMBNESS
24. ☐ COLD HANDS
25. ☐ COLD FEET
26. ☐ CHEST PAIN
27. ☐ CONSTIPATION
28. ☐ DIARRHEA
29. ☐ FATIGUE
30. ☐ TENSION
31. ☐ FEVER
32. ☐ HEADACHE
33. ☐ FAINTING
34. ☐ ANXIETY
35. ☐ SEIZURES
36. ☐ VISUAL DISTURBANCES
37. ☐ FORGETFULNESS
38. ☐ BLURRED VISION
39. ☐ DOUBLE VISION
40. ☐ CONFUSED
41. ☐ DISORIENTED
42. ☐ OTHER _____

☐ No Change
☐ Normal Duties
☐ Alternative Work Sched.

Work Status History Update

Occupation _____ Hours Worked Per Week: _____

☐ Yes ☐ No Have you lost time from work as a result of this injury?

If Yes, dates: _____

☐ Yes ☐ No Have you gone back to work? When? _____

If Yes, what status of work: ☐ Modified ☐ Regular

List restrictions you have been placed on: _____

If you have gone back to work, list activities that are:

Painful: _____

Difficult: _____

☐ Yes ☐ No Are you currently on disability (time loss), If Yes, do you want to go back to work doing your regular job?

If No, why not?: _____

☐ No Change Since Last Evaluation

Past Medical History Update

☐ Yes ☐ No Since you began treatment for this injury/injuries, have you had any accidents, illnesses, injuries, falls, surgeries, or hospitalizations? If Yes, please describe: _____

☐ Yes ☐ No Have you seen another health care provider for this or any other injury or illness? If Yes, please describe:

☐ Yes ☐ No Do you now take prescription drugs, over-the-counter drugs, vitamins, or supplements?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?
1.				
2.				
3.				

☐ No Change Since Last Evaluation

Family Health History Update

☐ Yes ☐ No Has there been any change in the health of your blood relatives (mother, father, brothers, sisters, children) What? _____

Other concerns or complaints?

My signature is an acknowledgement that all of the above statements are true. I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed.

patient signature: _____ Date: _____

parent/guardian/legal representative signature: _____ Date: _____

d.c./c.a. signature: _____ Date: _____