Reassessment Form

Welcome Back to Family First Chiropractic

Name _____ Phone: (H) _____ (W) _____
E-mail _____ Marital Status S M D W
If Pregnant, Due date: _____ Birth attendants: _____

Have you moved? Please complete the following section.
If not… skip it & complete the section labeled "current health condition

Address _____
City _____ Prov _____ PC _____

Current Health Condition *I'm here for wellness and have no complaints ☐ (Please skip to the next section)*

Reason for today's visit _____

Pain or problem started on_____ Why do *you* think the problem/pain started? _____

Pain is: Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Pain is interfering with: Work ☐ Sleep ☐ Routine ☐ Other _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is it worse during certain times of the day? _____ Is this condition getting progressively worse? Yes ☐ No ☐

Other Doctors seen: _____ Any home remedies? _____

Other symptoms:

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Ear Infections
☐ Neck Pain	☐ Pins & Needles in Arms	☐ Cold Sweats	☐ Asthma
☐ Sleeping Problems	☐ Numbness in Fingers	☐ Loss of Smell	☐ Allergies
☐ Back Pain	☐ Numbness in Toes	☐ Loss of Taste	☐ Frequent colds/flu
☐ Nervousness	☐ Shortness of Breath	☐ Diarrhea	☐ Menstrual problems
☐ Tension	☐ Fatigue	☐ Feet Cold	☐ IBS / Crohn's disease
☐ Irritability	☐ Depression	☐ Hands Cold	☐ Anxiety
☐ Chest Pains	☐ Light Bothers Eyes	☐ Stomach Upset	☐ Multiple Sclerosis
☐ Dizziness	☐ Loss of Memory	☐ Constipation	☐ Other Conditions or diseases_____
☐ Face Flushed	☐ Ears Ring	☐ Loss of Balance	
☐ Neck Stiff	☐ Fever	☐ Buzzing in Ear	_____

Accidents/Trauma/Injury History

Number of car accidents: _____ Approximate dates: _____

Any work, sports or other injuries: _____

Any medications you are currently taking: _____

Have you had surgery? Yes ☐ No ☐ What type? _____ When?_____

Any significant family medical conditions/history: _____

Give a brief description of the physical nature of your work:_____

Rate your occupational stress (1-10, 10 being the most stressful) _____

What types of physical, emotional and chemical stressors have you experienced _____

_____

Do you smoke? Yes ☐ No ☐ How many per day? _____ Do you drink alcohol? Yes ☐ No ☐ How many per week? ____

As a result of my chiropractic care, I would like to: *(Please check all that apply)*

☐ Feel better quickly
☐ Improved function and performance
☐ Have a healthier spine and better postural alignment
☐ Have a better quality of life

_____ _____
Signature Date