FK RH NC OM GW SM EH
Form 3 - Revised: 06/15/2010

W/C PIP Health

Delaware Back Pain & Sports Rehabilitation Centers

Follow - Up: History

Name: _____ **Date:** _____/_____/_____

Chief Complaint: _____

When during the day do you have your pain? _____ Is your pain constant? Yes ❑ No ❑

What makes your pain worse? _____

What makes your pain better? _____

Describe your pain (circle those that apply):

A. Neck – Sharp - Burning – Shooting – Achy - Knife -Like - Twisting
Pressure - Lancinating - Tooth -Ache - Deep - Heavy - Gnawing

Do you have any weakness or pain shooting down your arm?
☐ No ☐ Yes. If yes, describe_____

B. Mid Back – Sharp - Burning – Shooting – Achy - Knife -Like - Twisting
Pressure - Lancinating - Tooth -Ache - Deep - Heavy - Gnawing

C. Low Back – Sharp - Burning – Shooting – Achy - Knife -Like - Twisting
Pressure - Lancinating - Tooth -Ache - Deep - Heavy - Gnawing

Do you have any weakness or pain shooting down your leg? ☐ No ☐ Yes. If yes, describe...

_____

D. Other – i.e. Shoulder, Knee, Elbow, Wrist: _____

NEW HISTORY

Are you taking any New medications since last visit? _____

_____

Any New medication allergies or other allergies since last visit: _____

Any New illnesses, injuries, surgeries or hospitalizations since last visit: _____

_____

Is there a chance you are pregnant? ❑ yes ❑ no

Any change in your FAMILY HISTORY since your last visit (parents, siblings, children, grandparents)?

_____

Any change in your SOCIAL HISTORY since our last visit (marital status, employment, drugs, alcohol, tobacco, education)? _____

Circle any NEW symptoms since last visit.

- **Constitutional :** chills – fatigue – weight loss or gain – daytime sleepiness
- **Eyes :** eye pain/pressure – vision changes
- **Ears, Nose, Throat :** ringing in ears – hearing loss – dizziness - sinus pain – sore throat - snoring
- **Cardiovascular :** chest pain – palpitations – ankle swelling – wake short of breath
- **Respiratory :** cough - wheezing – shortness of breath – coughing up blood
- **Gastrointestinal :** trouble swallowing – abdominal pain – bowel irregularity heartburn – nausea/vomiting – rectal bleeding
- **Genitourinary :** painful urination - blood in urine - frequent urination prostate problems – loss of bladder control
- **Musculoskeletal :** joint aches - muscle aches
- **Skin :** rash - itching - hives - skin or hair changes
- **Neurological :** passing out - headache - weakness - numbness/tingling - memory loss - seizures
- **Psychological :** depression - anxiety/panic - nervousness – mood changes - tension
- **Endocrine :** feeling warmer than others - feeling cooler than others
- **Hematology/Lymphatics :** easy bruising - bleeding problems - sweating at night – swollen glands
- **Allergies:** environmental allergy – sneezing fits

Review of Systems

I have reviewed with the patient and everything not circled is unchanged from last visit, unless noted in history

Doctor Initials _____

Do you feel that formal rehab therapy has helped? ❑ yes ❑ no Not attending since last visit
Do you feel that chiropractic care has helped? ❑ yes ❑ no Not attending since last visit

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Reviewed by Doctor/PA (Initials) _____

Follow -Up History **Name:** _____ **Date:** _____/_____/_____

Your level of pain - please circle number

Your pain right now	no pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to the hospital
	0	1 - 2 - 3	4 - 5 - 6	7 - 8	9 - 10
Your average pain	no pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to the hospital
	0	1 - 2 - 3	4 - 5 - 6	7 - 8	9 - 10
Your worst pain	no pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to the hospital
	0	1 - 2 - 3	4 - 5 - 6	7 - 8	9 - 10

FUNCTION: Since your last visit how much has your pain interfered with your life:

1. **Ability to work:**
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
2. **Ability to sleep:**
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
3. **Ability to participate in social activities:**
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
4. **Ability to do household chores:**
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
5. **Relationship with family**:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
6. **Sexual activities**:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
7. **General Mood**:
   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
8. Do you need to lie down during the day due to pain? Yes No
9. If so, please circle how many times on average you need to lie down during the day. 1 2 3 4
10. Do you wake up during the night because of pain? Yes No
11. Do you feel rested in the morning? Yes No
12. Please circle the average number of hours you sleep at night?
    0 1 2 3 4 5 6 7 8 9 10

MEDICATIONS

1. Please write any medications that you may be on and write the daily dosage: _____

_____

_____

2. Side Effects: Please circle if you have any of the following side effects:

Constipation - Sedation - Nausea/Vomiting - Trouble Urinating - Trouble Sleeping
Swelling - Feeling Bad - Trouble Thinking - Sexual Problems

Doctor's Notes:

_____

_____

_____

Reviewed by Doctor/PA (Initials) _____

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