PATIENT UPDATE / EXAM

Please check the one that applies:

_____NEW INJURY _____RE-INJURY _____EXACERBATION

Date:_____ E-Mail:_____

Name:_____

Address: (If changed) ☐ SAME _____

Home/Cell Phone:_____Wk Phone:_____

Health History CHANGES: ☐ NO ☐ IF YES WHAT:

_____

Major Concerns:_____

_____

What happened?_____

What have you done for this?_____

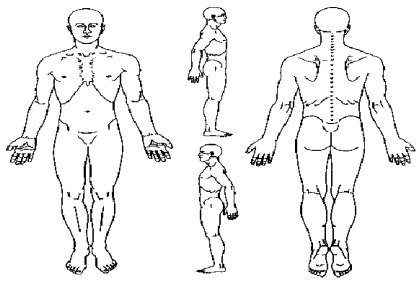
Who have you seen?_____

Did you lose time from work?_____If so, Dates:_____

Has your insurance changed since your last visit? Y N
(If so, please present your new card to the front desk.)

DO NOT WRITE BELOW THIS LINE

Please mark the area and type of pain on the drawings using the codes listed below. N=Numbness P=Pain A=Ache T=Tingling S=Stiffness S=Soreness



DOCTORS COMMENTS:

Bilateral Scales: L / ____ R / ____

Difference:_____

Posture: High L / R Ear
L / R Shoulder
L / R Hip
Forward/ Back Head Pos

Feet Turn L/R In/Out

Grip Strength: L / ____ ____ ____
R / ____ ____ ____

Average:

Other:

Lumbar ROM

90 _____ Flexion
30 _____ Extension
20 _____ R Lat Flex
20 _____ L Lat Flex
30 _____ R Rotation
30 _____ L Rotation

Cervical ROM

65 _____ Flexion
50 _____ Extension
45 _____ R Lat Flex
45 _____ L Lat Flex
80 _____ R Rotation
80 _____ L Rotation

☐ **SUB SCAN** ☐ **RE-EXAM** ☐ **PROCEED**

Staff Signature:_____

W1006