Chiropractic Care Center~ Franklin - Progress Update

Name _____ Age _____ Date _____

FOR NEW INJURY OR OVER 3 MONTH RE-EXAMS:

Briefly describe your area of complaint: Neck, Shoulders, Upper Back, Mid Back, Low Back, etc.

_____

Have you had any injuries since your last visit? ___ Yes ___ No Date of injury_____
___Work ___Auto ___Fall ___Other Briefly explain injury_____

Have you been under the care of another doctor (medical or chiropractor) since your last visit? __ Yes __ No
If yes, please explain_____

FOR REGULAR RE-EXAMS:

How would you classify your overall progress so far?
_____ Excellent _____ Very good _____ Good _____Fair _____ Poor

Your symptoms are: _____ Constant (100% of the time) _____ Frequent (75%of the time)
_____ Intermittent (50% of the time) _____ Occasional (25% of the time) _____ Completely gone

Please list any new injuries or health concerns:
_____ ____NONE

What symptoms have improved?

_____

What symptoms remain?

_____

Do you have any questions about your progress or treatment? _____ Yes _____ No

If the doctor has prescribed exercises, are you doing them:
_____ Yes _____ No _____ Sometimes _____ None shown

Please complete the backside of this form ⟶

Patient signature_____ Date_____

Established patient update form for Electronic Health Record

To help us keep your records up to date please include any changes since _____for all of the questions below.

Have you had any illness, surgery or hospitalizations?

Name of Illness	**Date of Illness**

Type of surgery	**Date of surgery**	**Result of surgery?**

Date of hospitalization	**Reason for hospitalization**	**Name of hospital**

Have you been Immunized?

Date of vaccine	**Name of vaccine**	**Reaction to vaccine**	**Site of vaccine given**

Family History:

	DIABETES	HEART	KIDNEY	CANCER	BACK	STROKE	HIGH B.P.	DECEASED
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐

If deceased, please list the cause: _____

Social History:

Habits: ☐ Smoking How much? _____ ☐ Alcohol How much? _____

☐ Caffeine How much? _____ ☐ Drug Use How much? ____

☐ Exercise activities & How often?_____

Occupational History:

Employer name _____ Status: Full time/Part time/Other _____

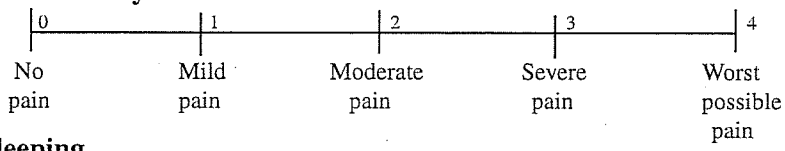
Occupation: _____ Start Date: _____ End date:_____

Functional Rating Index

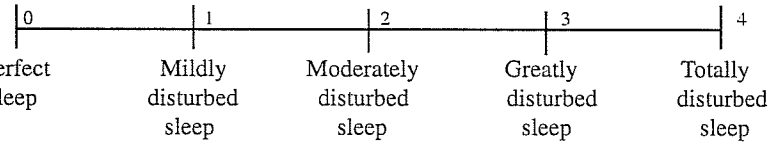
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

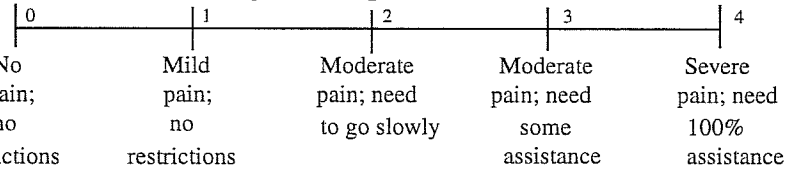
1. Pain Intensity



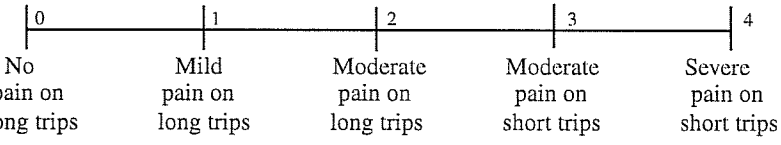
2. Sleeping



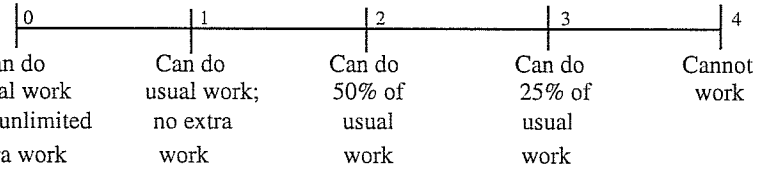
3. Personal Care (washing, dressing, etc.)



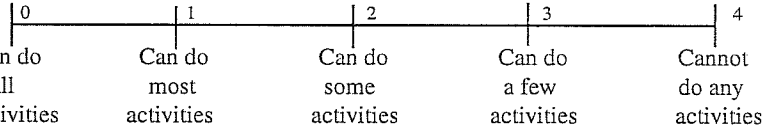
4. Travel (driving, etc.)



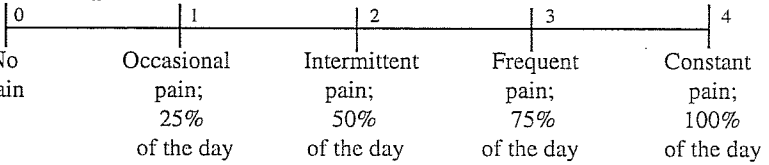
5. Work



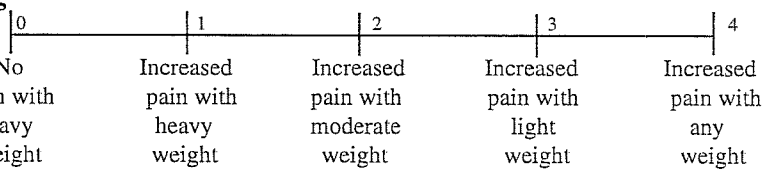
6. Recreation



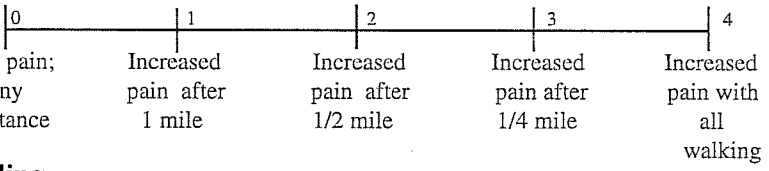
7. Frequency of pain



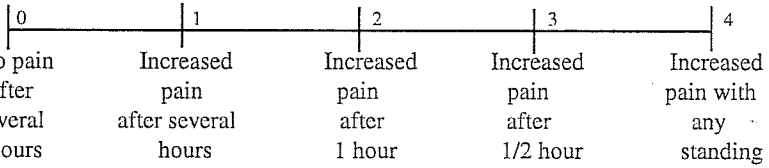
8. Lifting



9. Walking



10. Standing



Name _____
PRINTED

Total Score _____

_____
Signature

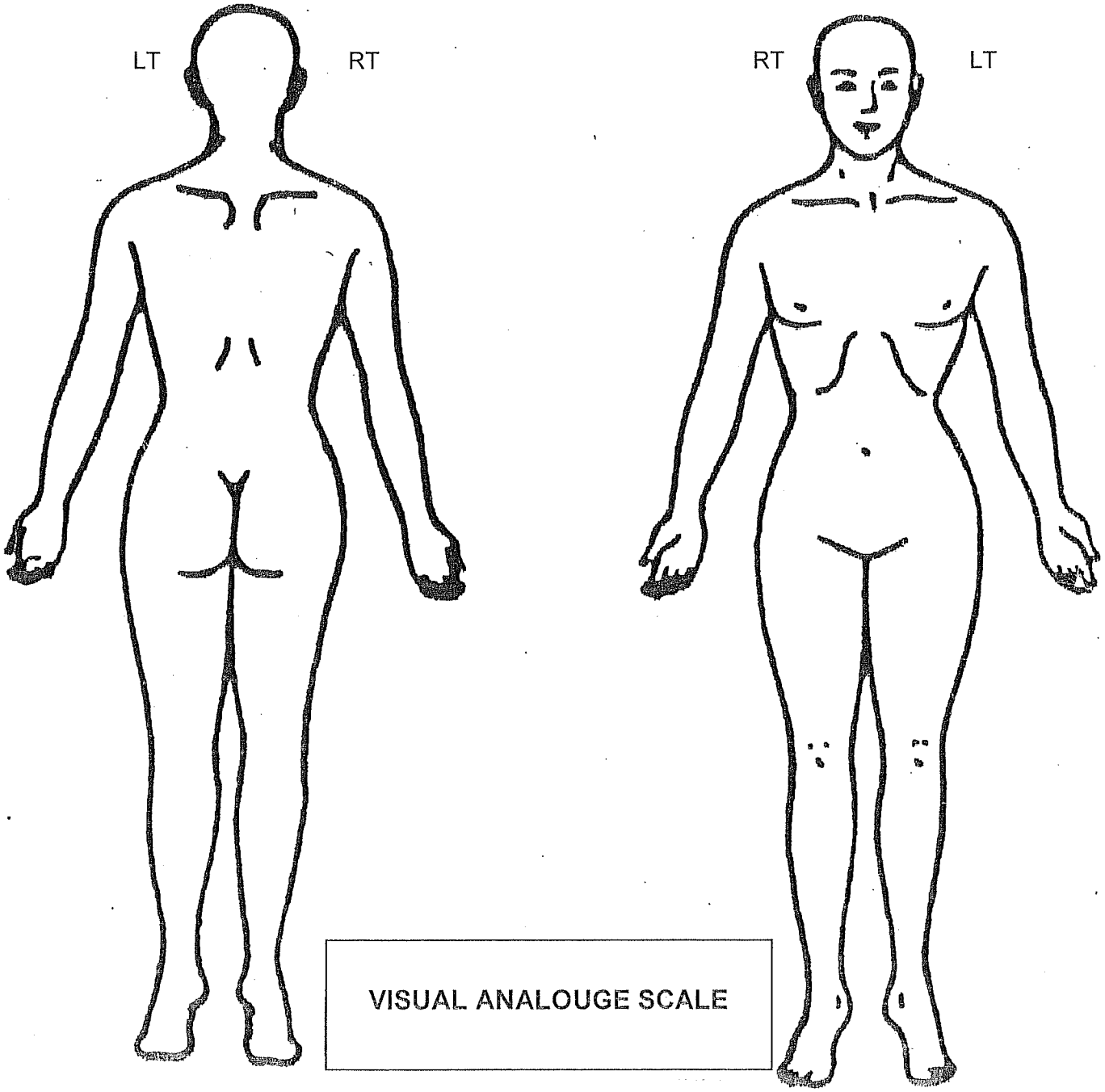
_____
Date

PAIN DRAWING

NAME: _____ DATE: _____

Please be sure to fill this out extremely accurately. Mark the areas on your body where you feel the described sensation(s) Use the appropriate symbol(s); mark the areas of radiating pain and include all affected areas

Numbness ----- Pins & Needles ooooo Burning Pain xxxx Stabbing Pain ///// Aching Pain (((((



VISUAL ANALOUGE SCALE

	None										Unbearable
a) Pain Right Now	0	1	2	3	4	5	6	7	8	9	10
b) Average Pain	0	1	2	3	4	5	6	7	8	9	10
c) At best	0	1	2	3	4	5	6	7	8	9	10
d) At worst	0	1	2	3	4	5	6	7	8	9	10