

Patient History Update

Name: _____ Address: _____

Postal Code: _____ Email: _____

Phone: (H) _____ (C) _____ (W) _____ Ext. _____

1) Reason for today's consultation: Spinal check-up _____ Other: _____

2) How long have you had your primary complaint? _____

3) How did it start? _____

4) Is it getting better? _____ worse? _____ staying the same? _____ What makes it Better/Worse? _____

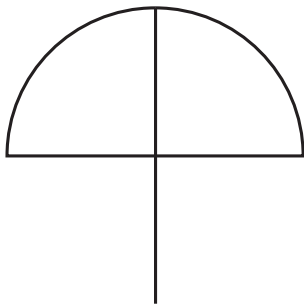
5) Any injuries/surgeries since your last visit? No _____ Yes _____ Explain: _____

6) Any current medications?: Pain killers ____ Anti-Inflammatory ____ Muscle relaxants ____ Birth control ____ Blood thinners ____

Other (please specify) _____

7) Diagnosed conditions?: High blood pressure ____ Diabetes ____ Arthritis ____ Cancer ____ Stroke ____ Transient Ischemic attacks ____

Other (please list) _____

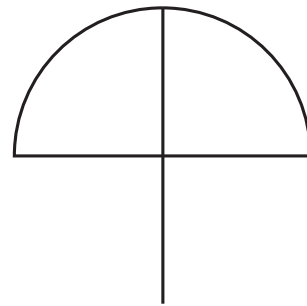


DIR'S C5 - Rt _____ L _____
 C6 - Rt _____ L _____
 C7 - Rt _____ L _____
 L4 - Rt _____ L _____
 S1 - Rt _____ L _____

Motor

Sensory

Grip



L/S

C/S Neutral 1 2 3 4 5
 Rt For. Comp 1 2 3 4 5
 Lt For. Comp 1 2 3 4 5

OTHER

Distraction

Rt Kemp's Sign 1 2 3 4 5

Lt Kemp's Sign 1 2 3 4 5

Date: _____ Subjective: HA C/S T/S L/S

Initials	Spheniod R L	Nasal	Ant ribs R L	Standing	Sitting	POSub	Prone	Hip AP	Calc R L	Exercise C T L	Core
	Occiput R L	Maxilla R L	U M L Lat	Right				Tibia/ Fib	Nav R L	Stretches	
	Temporal R L	Zygoma R L	Scapula R L						Cubiod R L		
	Parietal R L	Orbit	med lat	1 2 3 4 5 6 7 1	2 3 4 5 6 7 8 9	10 11 12	1 2 3 4 5	Sacrum Cx	Pubis	Post adj	IMP NNAR
Account	Zyg Arch R L	TMJ PA R L	Radius R L								
TX PAID BAL	Frontal S R L	Hyoid	Ulna R L	Left				Tibia/ Fib	Talus R L		
	Mastoid R L	Sternum R L	Carpals R L					Hip AP		Next	WK(S)
	Sutures	Scaleni R L	Shld In Ex El								

Dx:
DDx: