



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

Reviewed by Doctor/PA (Initials) \_\_\_\_\_

**Follow -Up History Name:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Your level of pain - please circle number**

Your pain right now

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

Your average pain

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

Your worst pain

no pain 0	tolerable no pain meds 1 - 2 - 3	need to take medicine 4 - 5 - 6	take narcotics go to the ER 7 - 8	admit to the hospital 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) \_\_\_\_\_

2006 Foulk Rd, Suite B, Wilmington, DE 19810 ~ 302-529-8783 + 700 Lea Blvd, Suite 102, Wilmington, DE 19802 ~ 302-529-8783  
87B Omega Drive, Newark, DE 19713 ~302-733-0980 + 29 North East St, Smyrna, DE 19977 ~302-389-2225  
2600 Glasgow Ave, Suite 210, Newark, DE 19702 ~ 302-832-8894 + 2150 New Castle Ave, New Castle, DE 19720 ~ 302-529-8783  
200 Banning Street, Suite-350, Dover, DE 19904 302-730-8848

