**RE–ASSESSMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’s name |  | Date of birth |  | (DD)-MM-YY |

**Current Condition**

If you have a specific condition, please complete the questions, otherwise go on to the next section of this form.

|  |  |
| --- | --- |
| What is your major complaint? |  |
| How long have you had this condition? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Did it begin: | Is the condition: |  | Is there pain: |
| Suddenly | Getting worse | Consistent | At right |
| Gradually | Getting better | Comes and goes | On coughing or sneezing |

|  |  |
| --- | --- |
| Describe if the pain travels: |  |

Please mark your area(s) of concern using the symbols that you feel best describe what you are experiencing:

|  |  |  |
| --- | --- | --- |
| Numbness - - - - - - | |  |
| Burning # # # # # | |
| Stabbing ++++++ | |
| Pins & . . . . . . .  Needles . . . . . . . | |
| Aching \* \* \* \* | |
| Stiff/ | / / / / / / |
| Tight |

Place an “X” on the line to indicate the amount of pain/discomfort associated with your condition:

No Pain [0…..1……2……3…….4……5…….6……7……8…..9…..10] Worst Pain Ever

|  |  |
| --- | --- |
| What activities or positions cause aggravation: |  |

|  |  |
| --- | --- |
| What activities or position provide relief: |  |

|  |  |
| --- | --- |
| Please describe any past episodes: |  |

|  |  |
| --- | --- |
| If there was an injury or event that lead up to this condition, please describe: |  |
|  | |

If any health practitioner has previously treated you for this condition, please specify:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Location: |  | When: |  | Nature of Treatment |  |
| Can we follow up? ( *Please circle*) Yes No | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Has anyone else in your family had a similar complaint? | | |  |
| Other areas of concern: | |  | |
| Previous injuries: |  | | |