Doctor: ____________________________

KIEKHOEFER CHIROPRACTIC
8619 West Point Douglas Rd., Suite 110
Cottage Grove, MN 55016
651-458-0094

Re-Exam Form

List any major illnesses, accidents, or trauma since your last visit: ____________________________________
____

General physical activity level: ___No regular exercise ___Light exercise ___ Moderate exercise ___Heavy exercise

Please describe your current symptoms (be as specific as possible): _____________________________________
____

What activities aggravate your symptoms? ____

Is there anything that has relieved your symptoms? ___Yes ___No Describe______________________________
____

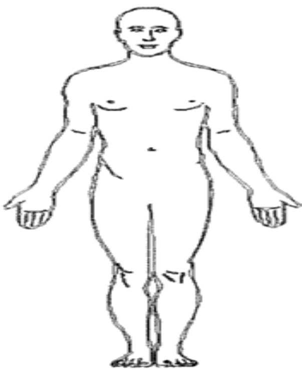
What type of pain are you experiencing? Please check all that apply.
___Sharp ___Dull ___Ache ___Burning ___Throbbing ___Spasm ___Numbness ___Tingling ___Shooting

Does the pain radiate into your arms or legs? ___Yes ___No ___right ___left ___arm ___leg

Frequency of symptoms throughout the day? ___100% ___75% ___50% ___25% ___10% ___Only with activity

Do your symptoms interfere with: ___Work ___Sleep ___Hobbies ___Daily Routine Explain_________________
____

Where is the problem? Please use the lines below to explain.



Front ______________________________________
____
____

Back ______________________________________
____
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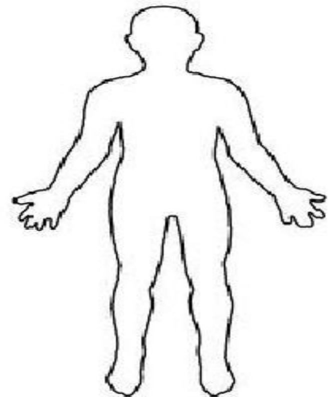

On a scale of 1-10 (1 least, 10 most), please rate:
The severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

How would you describe your satisfaction with treatment here? ____Very pleased ____Pleased ____Displeased
Additional comments: ____

Print Patient Name ____Date _________________

Patient/Guardian Signature ____