PORTLAND
CHIROPRACTIC · NEUROLOGY

Re-examination Intake

CONFIDENTIAL HEALTH INFORMATION
Clinic ID: Date:

Patient Information

Last name First name MI Prefer to be called

Health Complaints

*What is your **primary** complaint?*_____

*How long have you been experiencing this primary complaint?*_____

*How has this progressed over time?*_____

*Using the scale below, rate how your primary complaint **currently** affects your life (mark only one box)*

1	2	3	4	5	6	7	8	9	10
Symptoms that do not affect life in any way	Symptoms that slightly affect life	Symptoms that don't affect daily activities	Symptoms that affect daily activities	Symptoms that prevent performing daily activities	Symptoms that limit work schedule	Symptoms that prevent attending work	Symptoms that prevent work and all personal activities	Symptoms that keep me from leaving home	Symptoms that cause thoughts of suicide

*Do you have any additional symptoms (musculoskeletal, neurological, or otherwise) that are related to this? If yes, please list:*_____

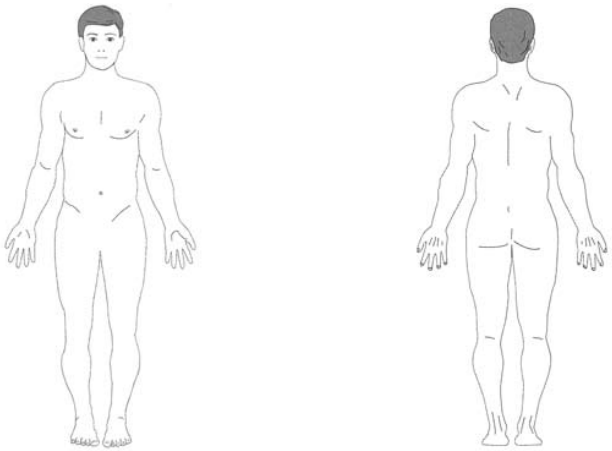
List any other health conditions/complaints you are currently experiencing:

1) _____ *2)* _____

3) _____ *4)* _____

Please use the images on the right to mark the areas affected by your chief complaint and any of the associated symptoms listed above.

Include any additional descriptors or comments concerning your health complaints if necessary.



❖*Medications/Vitamins/Supplements:*

❖*Recent changes in health history:*

Additional comments/concerns regarding your health:

Patient Signature Date: