REASSESSMENT FORM

Name: _____ Date: _____

If you have an injury to be covered by the Workplace Safety and Insurance Board (WSIB) or automobile insurance, please inform the receptionist.

What is your major complaint? _____

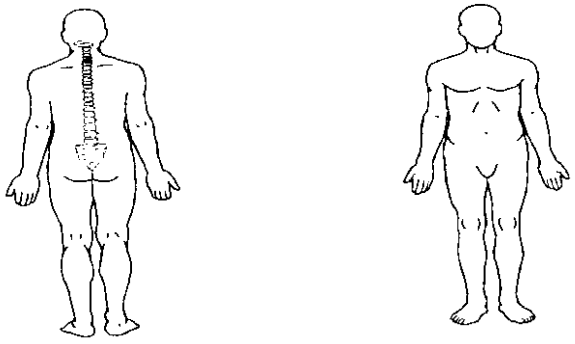
How long have you had this condition? _____

Did it begin:	Is the condition:		Is there pain:
☐ Suddenly	☐ Getting worse	☐ Consistent	☐ At night
☐ 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

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

_____

Which activities or positions cause aggravation? _____

Which activities or positions provide relief? _____

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

Location: _____ When: _____ Nature of Treatment: _____

May we follow up? ☐ Yes ☐ No

Consent to Consultation and Examination

I consent to consultation and examination to determine if chiropractic treatment would be beneficial to me. I understand that the examination may cause some tenderness and/or discomfort, but that it will be short-lived.

Name (print): _____ Signature: _____ Date: _____

Dr. Jennifer Heick ☐ Dr. Rebecca Blackburn ☐ Dr. Jillian Clarkson ☐
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