

# 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.**

Date of Last Visit: \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Did it begin:

☐ Suddenly

☐ Gradually

Is the condition:

☐ Getting worse

☐ Getting better

☐ Consistent

☐ Comes and goes

Is there pain:

☐ At night

☐ 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 -----

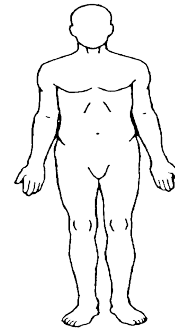
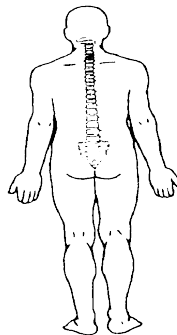
Burning #####

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 led 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

In the past 15 years, please list any diagnoses, injuries, hospitalizations, medications or other health issues that the chiropractor should be aware of: \_\_\_\_\_

## 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: \_\_\_\_\_



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