

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 Consistent
 Getting better Comes and goes

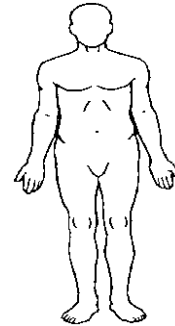
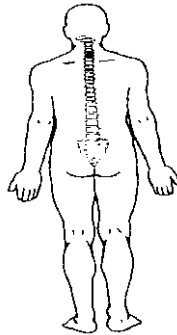
Is there pain:

- 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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