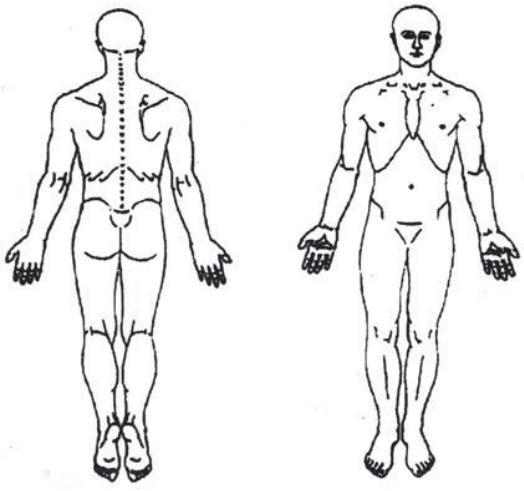
ALDANA CHIROPRACTIC

Patient Name _____

Please complete the following ***three*** (3) questions regarding how you feel today.

1. How do you feel today?

MARK AN X ON THE PAGE WHERE YOU HAVE PAIN
OR OTHER SYMPTOMS



Current Complaint:

_____

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

2. Are you getting better?

Current condition(s)/complaint(s) **Rate your overall progress since starting care**

a) _____ _____% 0 = No Improvement and 100% = Fully Recovered

b) _____ _____% 0 = No Improvement and 100% + Fully Recovered

In the past on average, how often have your symptoms been present?

(Intermittent) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, household chores?)

_____

0 1 2 3 4 5 6 7 8 9 10

No Interference — Unable to carry on activities

3. Is there anything new?

Have you had any new condition(s)/complaint(s)? ☐ NO ☐ YES

Have you had any re-injuries or events that have prolonged your recover? ☐ NO ☐ YES

Explain:_____

_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature_____ Date_____

CHANGE OF ADDRESS/PHONE # ☐ YES ☐ NO CELL # _____HOME #_____

_____

STREET CITY STATE ZIP

Name:_____ Age: _____ Date: _____

VITALS: HEIGHT: WEIGHT:	PULSE: BP:	RESPIRATION: TEMPERATURE:

Palpation:

Range of Motion
Cervical

ISD Level

C/S

T/S

Thoraco-Lumber

L/S

Left Right Right Left

Neurological Exams (if indicated)

Sensation - □ WNL DTRs (0-4) □ WNL Myotomes (0-5) □ WNL Notes: _____

Left Root Right Left Root Right Left Root Right _____

_____ _____ _____ _____

CERVICAL	**(LT)**	**LUMBAR**	**(RT)**	**ORTHOPEDIC**	**EXAMS**
_____	(P) (+) (-)	Compression	Neutral	(P) (+) (-)	_____
_____	(P) (+) (-)	Compression	Max For.	(P) (+) (-)	_____
_____	(P) (+) (-)	Distraction	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Shoulder	Depression	(P) (+) (-)	_____
_____	(P) (+) (-)	Kemp's	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Valsalva's	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	SLR/WLR	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Milgram's	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Yeoman's	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Hibb's	Test	(P) (+) (-)	_____

UPPER	**LOWER**			**EXTREMITY**	**ORTHOPEDIC EXAMS**
_____	(P) (+) (-)	Speeds	Neutral	(P) (+) (-)	_____
_____	(P) (+) (-)	Supraspinatus	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Impingement	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Dugas	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Apley's	Distraction	(P) (+) (-)	_____
_____	(P) (+) (-)	Apley's	Compress	(P) (+) (-)	_____
_____	(P) (+) (-)	Drawer(knee)	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	McMurray's	Test	(P) (+) (-)	_____

BALANCE	**VASCULAR**			**EXAMS**
_____	(P) (+) (-)	Allen's	Test	(P) (+) (-)	_____
_____	(P) (+) (-)	Maigne's	Test	(P) (+) (-)	_____

Date: _____ Clinician's Signature: _____