

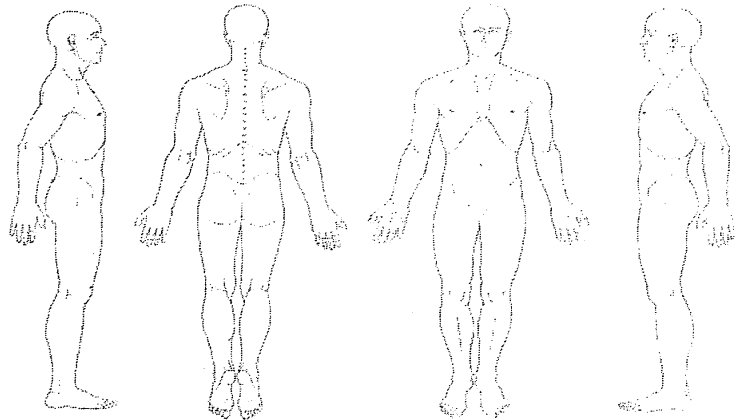
# Patient Re-Exam Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

1. Describe your current symptoms \_\_\_\_\_  
\_\_\_\_\_

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp            ④ Shooting
- ② Dull ache       ⑤ Burning
- ③ Numb            ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. How bad are your symptoms at their:

- |           |      |   |   |   |   |   |   |   |   |   |  |  |            |
|-----------|------|---|---|---|---|---|---|---|---|---|--|--|------------|
|           | None |   |   |   |   |   |   |   |   |   |  |  | Unbearable |
| a. worst: | ①    | ② | ③ | ④ | ⑤ | ⑥ | ⑦ | ⑧ | ⑨ | ⑩ |  |  |            |
| b. best:  | ⑩    | ⑨ | ⑧ | ⑦ | ⑥ | ⑤ | ④ | ③ | ② | ① |  |  |            |

6. How do your symptoms affect your ability to perform daily activities?

- |               |                               |                                    |                                  |  |                              |   |   |   |   |
|---------------|-------------------------------|------------------------------------|----------------------------------|--|------------------------------|---|---|---|---|
| ①             | ②                             | ③                                  | ④                                | ⑤  | ⑥                            | ⑦ | ⑧ | ⑨ | ⑩ |
| No complaints | Mild, forgotten with activity | Moderate, interferes with activity | Limiting, prevents full activity | Intense, preoccupied with seeking relief | Severe, no activity possible |   |   |   |   |

7. What do you hope to get from your visit/treatment (select all that apply):

- ① Reduce symptoms                      ③ Explanation of condition/treatment                      ⑤ How to prevent this from occurring again
- ② Resume/increase activity              ④ Learn how to take care of this on my own                      ⑥

8. Please list your Primary Doctor's

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

8b. When was the date of your last visit? \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

DC Patient Outcomes Form  
(version 1.1)

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PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Last Name																				First Name																		
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1. In general, would you say your health is

	Excellent	Very good	Good	Fair	Poor
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

	Yes, limited a lot	Yes, limited a little	No, not limited at all
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Climbing several flights of stairs

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. Were limited in the kind of work or other activities

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. Accomplished less than you would like

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Did work or other activities less carefully than usual

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past week...

9. Have you felt calm and peaceful?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Did you have a lot of energy?

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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11. Have you felt downhearted and depressed?

	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
14. On average		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
15. At its best		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
16. At its worst		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Service Date:  /  /

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**DC Patient Intake Form  
(version 1.1)**

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<b>Last name</b>		<b>First name</b>	
<b>PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ● )</b>			
<b>1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.</b>			
<input type="radio"/> Neck	<input type="radio"/> Shoulder	<input type="radio"/> Hip	<input type="radio"/> Headache
<input type="radio"/> Upper/mid back	<input type="radio"/> Elbow	<input type="radio"/> Knee	<input type="radio"/> Other
<input type="radio"/> Lower back	<input type="radio"/> Wrist	<input type="radio"/> Ankle	
	<input type="radio"/> Hand	<input type="radio"/> Foot	
<b>2. When did this problem first begin?</b>			
<input type="radio"/> Less than 1 month ago <input type="radio"/> 1-3 months ago <input type="radio"/> 4-6 months ago <input type="radio"/> 7-12 months ago <input type="radio"/> More than 1 year ago			
<b>Has this problem...</b>			<b>No    Yes</b>
<b>3. ... resulted from a work injury (i.e. workers' compensation insurance claim)?</b>			<input type="radio"/> <input type="radio"/>
<b>4. ... resulted from a motor vehicle accident (i.e. no fault insurance claim)?</b>			<input type="radio"/> <input type="radio"/>
<b>5. ... recently been evaluated by a medical doctor?</b>			<input type="radio"/> <input type="radio"/>
<b>Since this problem began, have you noticed...</b>			<b>No    Yes</b>
<b>6. ... so much weakness in both your arms that you are unable to lift them?</b>			<input type="radio"/> <input type="radio"/>
<b>7. ... so much weakness in both your legs that you are unable to walk without help?</b>			<input type="radio"/> <input type="radio"/>
<b>8. ... difficulty controlling your bowel or bladder, or have you been unable to urinate?</b>			<input type="radio"/> <input type="radio"/>
<b>9. ... pain in your chest, shortness of breath, or coughing up blood?</b>			<input type="radio"/> <input type="radio"/>
<b>10. ... that one leg felt more warm, more swollen, more red, or more tender than the other?</b>			<input type="radio"/> <input type="radio"/>
<b>Have you recently...</b>			<b>No    Yes</b>
<b>11. ... had blurred vision, double vision, dizziness, or fainting?</b>			<input type="radio"/> <input type="radio"/>
<b>12. ... had any type of infection, fever, or chills?</b>			<input type="radio"/> <input type="radio"/>
<b>13. ... had any type of surgery, surgical procedure, or medical procedure?</b>			<input type="radio"/> <input type="radio"/>
<b>14. ... lost a lot of weight without really trying to (i.e. without being on a diet)?</b>			<input type="radio"/> <input type="radio"/>
<b>15. ... had any type of accident, fall, or trauma?</b>			<input type="radio"/> <input type="radio"/>
<b>Have you ever...</b>			<b>No    Yes</b>
<b>16. ... been diagnosed with cancer?</b>			<input type="radio"/> <input type="radio"/>
<b>17. ... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?</b>			<input type="radio"/> <input type="radio"/>
<b>18. ... been diagnosed with a weakened immune system?</b>			<input type="radio"/> <input type="radio"/>
<b>19. ... used any injected drugs (i.e. non-prescription drugs)?</b>			<input type="radio"/> <input type="radio"/>
<b>20. ... used steroids such as prednisone for more than 4 weeks?</b>			<input type="radio"/> <input type="radio"/>
<b>Is this problem something that ...</b>			<b>No    Yes</b>
<b>21. ... you've had before?</b>			<input type="radio"/> <input type="radio"/>
<b>22. ... generally gets worse (i.e. more severe or frequent) with movement, activity, or exercise?</b>			<input type="radio"/> <input type="radio"/>
<b>23. ... generally gets better (i.e. less severe or frequent) with rest?</b>			<input type="radio"/> <input type="radio"/>
<b>24. ... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?</b>			<input type="radio"/> <input type="radio"/>
<b>25. ... is also being treated by a health professional other than a chiropractor?</b>			<input type="radio"/> <input type="radio"/>

**Service Date:**  /  /

M M    D D    Y Y Y Y

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## Turner Chiropractic Office

84-02 51<sup>st</sup> Avenue  
Elmhurst, NY 11373  
718.565.9090  
718.565.9315 fax

### Consent to Treat Form

I have received information about my condition and proposed chiropractic treatment program., as well as alternative coursed of care, the benefits, the risk ant the side effects of the treatment and the consequences of not having the proposed treatment.

I understand and I am informed that, as in all healthcares, in the practice of chiropractic there are some rare risks to treatment, including but not limited to muscle strains and sprains, fractures, dislocations, disc, injuries and strokes. I do not expect Turner Chiropractic to be able to anticipate or explain all risks and complications. I will to rely on the doctor to exercise appropriate clinical judgment during the course of the treatments, which is believed at the time based upon the facts then known, is in my best interests.

Turner Chiropractic has responded to all of my requests for information about the proposed treatments. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content.

By signing below, I consent to chiropractic treatment.

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Patient Name	Signature of Patient	Date
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Parent/Guardian	Signature Parent/Guardian	Date
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Witness Name	Signature of Witness	Date
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Doctor's Initials		Date
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