


CLINICAL RE-EVALUATION

DATE OF INITIAL EXAMINATION

DATE OF MOST RECENT EXAMINATION

Dear Patient:
In Order to assist us in evaluating your progress please fill in section A.

Use a **No. 2 pencil** to mark your answers. When marking in an **Other** bubble please explain in the space allowed. Fill in bubbles **completely** as indicated here:  **Erase** changes cleanly. **Do not fold** form.

Patient Name: _____

| MO | DAY | YEAR | DR# | PATIENT NUMBER | | | | | | | | | | | | | | | | | | |
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A. PATIENT SECTION

1. What percentage (%) of your original symptoms do you still have?

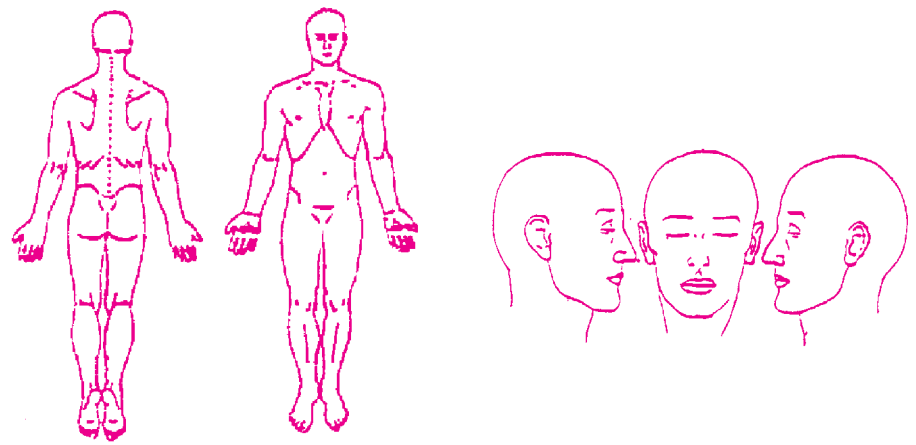
- 10%
- 20%
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%

2. What are your major complaints?

None

| | Pain | | Numbness | | Tingling | |
|------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | R | L | R | L | R | L |
| Head | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Neck | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Upper Back | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mid Back | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lower Back | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Shoulder | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Arm | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Forearm | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hand | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Buttock | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hip | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Thigh | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Leg | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Foot | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

3. Please mark the location of your pain on the figures below



4. Currently your pain is aggravated by

- Coughing
- Sneezing
- Straining At Stool
- Neck Movement
- Reaching
- Lifting
- Bending
- Sitting
- Standing
- Walking
- Other

5. Since your symptoms began, have you noticed a change in

- Bowel Function
- Bladder Function
- Ability To Maintain An Erection

6. Since your last examination, have you had any

- Accidents
- Illnesses
- Treatments or Examinations Elsewhere
- Other

END OF PATIENT SECTION

B. NEUROLOGIC ASSESSMENT

1. DEEP TENDON REFLEXES

All grade 2 and Symmetric

| Except: | Right | | | | | Left | | | | |
|--------------------|-------|---|---|---|---|------|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 0 | 1 | 2 | 3 | 4 |
| a. Biceps | A | A | A | A | A | A | A | A | A | A |
| b. Triceps | B | B | B | B | B | B | B | B | B | B |
| c. Brachioradialis | C | C | C | C | C | C | C | C | C | C |
| d. Patellar | D | D | D | D | D | D | D | D | D | D |
| e. Achilles | E | E | E | E | E | E | E | E | E | E |

2. MOTOR EXAMINATION

a. UPPER EXTREMITY MOTOR FUNCTION

No Motor Loss

| Except: | Right | | | | | | Left | | | | | |
|-----------------------|-------|---|---|---|---|---|------|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. Shoulder Abduction | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2. Wrist Extension | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3. Wrist Flexion | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 4. Finger Extension | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| 5. Finger Flexion | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| 6. Finger Abduction | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| 7. Finger Adduction | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

b. LOWER EXTREMITY MOTOR FUNCTION

No Motor Loss

| Except: | Right | | | | | | Left | | | | | |
|------------------------------|-------|---|---|---|---|---|------|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. Hip Flexion | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 2. Leg Extension | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 3. Foot Dorsi-Flexion | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| 4. Great Toe Dorsi-Flexion | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| 5. Foot Plantar-Flexion | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| 6. Great Toe Plantar-Flexion | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 | 6 |
| 7. Foot Eversion | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |

| | | Positive | Negative |
|-----------|-------|----------|----------|
| Heel Walk | Right | B | B |
| | Left | 1 | 1 |
| Toe Walk | Right | B | B |
| | Left | 1 | 1 |

3. SENSORY PINWHEEL TESTING

No Sensory Deficit

| Except: | Hypo | | Hyper | | T1 <th colspan="2">Hypo</th> <th colspan="2">Hyper</th> | Hypo | | Hyper | |
|---------|------|---|-------|---|---|------|----|-------|----|
| | R | L | R | L | | R | L | R | L |
| C1 | 1 | 1 | 1 | 1 | T2 | 2 | 2 | 2 | 2 |
| C2 | 2 | 2 | 2 | 2 | T3 | 3 | 3 | 3 | 3 |
| C3 | 3 | 3 | 3 | 3 | T4 | 4 | 4 | 4 | 4 |
| C4 | 4 | 4 | 4 | 4 | T5 | 5 | 5 | 5 | 5 |
| C5 | 5 | 5 | 5 | 5 | T6 | 6 | 6 | 6 | 6 |
| C6 | 6 | 6 | 6 | 6 | T7 | 7 | 7 | 7 | 7 |
| C7 | 7 | 7 | 7 | 7 | T8 | 8 | 8 | 8 | 8 |
| C8 | 8 | 8 | 8 | 8 | T9 | 9 | 9 | 9 | 9 |
| | | | | | T10 | 10 | 10 | 10 | 10 |
| | | | | | T11 | 11 | 11 | 11 | 11 |
| | | | | | T12 | 12 | 12 | 12 | 12 |

| Except: | Hypo | | Hyper | | S1 <th colspan="2">Hypo</th> <th colspan="2">Hyper</th> | Hypo | | Hyper | |
|---------|------|---|-------|---|---|------|---|-------|---|
| | R | L | R | L | | R | L | R | L |
| L1 | 1 | 1 | 1 | 1 | S2 | 2 | 2 | 2 | 2 |
| L2 | 2 | 2 | 2 | 2 | S3 | 3 | 3 | 3 | 3 |
| L3 | 3 | 3 | 3 | 3 | S4 | 4 | 4 | 4 | 4 |
| L4 | 4 | 4 | 4 | 4 | S5 | 5 | 5 | 5 | 5 |
| L5 | 5 | 5 | 5 | 5 | | | | | |

4. PLANTAR RESPONSE

| | Downgoing | Absent | Upgoing |
|-------|-----------|--------|---------|
| Right | B | B | B |
| Left | 1 | 1 | 1 |

5. OF ADDITIONAL NOTE

C. ORTHOPEDIC EXAMINATION

1. CERVICAL SPINE

a. RANGE OF MOTION

Normal In All Positions

| Except: | Normal | Mildly Restricted | Moderately Restricted | Severely Restricted | With Pain |
|--------------------------|------------|-------------------|-----------------------|---------------------|-----------|
| | 1. Flexion | 1 | 1 | 1 | 1 |
| 2. Extension | 2 | 2 | 2 | 2 | 2 |
| 3. Right Lateral Flexion | 3 | 3 | 3 | 3 | 3 |
| 4. Left Lateral Flexion | 4 | 4 | 4 | 4 | 4 |
| 5. Right Rotation | 5 | 5 | 5 | 5 | 5 |
| 6. Left Rotation | 6 | 6 | 6 | 6 | 6 |

b. COMPRESSION TEST

Normal In All Positions

| Except: | | Neck Pain | Upper Extremity Pain | |
|--------------------------|---|-----------|----------------------|------|
| | | | Right | Left |
| 1. Neutral | 1 | 1 | 1 | 1 |
| 2. Flexion | 2 | 2 | 2 | 2 |
| 3. Extension | 3 | 3 | 3 | 3 |
| 4. Right Lateral Flexion | 4 | 4 | 4 | 4 |
| 5. Left Lateral Flexion | 5 | 5 | 5 | 5 |

c. VALSALVA

Positive

Negative

d. DISTRACTION

Positive

Negative

e. OF ADDITIONAL NOTE

PLEASE MAKE NO MARKS IN THIS AREA

C. ORTHOPEDIC EXAMINATION (Continued)

2. LUMBAR SPINE

a. RANGE OF MOTION

○ Normal In All Positions

| Except: | Normal | Mildly Restricted | Moderately Restricted | Severely Restricted | With Pain |
|--------------------------|--------|-------------------|-----------------------|---------------------|-----------|
| 1. Flexion | ① | ① | ① | ① | ① |
| 2. Extension | ② | ② | ② | ② | ② |
| 3. Right Lateral Flexion | ③ | ③ | ③ | ③ | ③ |
| 4. Left Lateral Flexion | ④ | ④ | ④ | ④ | ④ |
| 5. Right Rotation | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ |
| 6. Left Rotation | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ |

b. Root Tension Signs

1. Straight Leg Raise

| | Full And Pain Free | Back Pain | Leg Pain | 30 | 45 | 60 | 90 |
|-------|--------------------|-----------|----------|----|----|----|----|
| Right | Ⓡ | Ⓡ | Ⓡ | Ⓡ | Ⓡ | Ⓡ | Ⓡ |
| Left | Ⓛ | Ⓛ | Ⓛ | Ⓛ | Ⓛ | Ⓛ | Ⓛ |

| | Positive | Negative |
|-------------------|----------|----------|
| 2. Braggard's | | |
| Right | Ⓡ | Ⓡ |
| Left | Ⓛ | Ⓛ |
| 3. Well Leg Raise | | |
| Right | Ⓡ | Ⓡ |
| Left | Ⓛ | Ⓛ |
| 4. Lindner | Ⓛ | Ⓛ |

c. VALSALVA

| Positive | Negative |
|----------|----------|
| ○ | ○ |

d. KEMP'S

| | Right | Left |
|-----------------------|-------|------|
| 1. Full And Pain Free | ○ | ○ |

| | Positive | Negative |
|--------------------|----------|----------|
| 2. To Right - Pain | | |
| a. Back | Ⓡ | Ⓡ |
| b. Right Leg | Ⓡ | Ⓡ |
| c. Left Leg | Ⓛ | Ⓛ |
| 3. To Left - Pain | | |
| a. Back | Ⓡ | Ⓡ |
| b. Right Leg | Ⓡ | Ⓡ |
| c. Left Leg | Ⓛ | Ⓛ |

e. FABERE PATRICK

| | Positive | Negative |
|-------|----------|----------|
| Right | Ⓡ | Ⓡ |
| Left | Ⓛ | Ⓛ |

f. POSTURAL SIGNS

| | Positive | Negative |
|---------|----------|----------|
| Minor's | Ⓜ | Ⓜ |
| Adam's | Ⓜ | Ⓜ |

| | Right | Left | Flexion |
|----------|-------|------|---------|
| Antalgia | ○ | ○ | ○ |

g. OF ADDITIONAL NOTE

| |
|---|
| ○ |
| |
| |
| |
| |
| |
| |
| |

D.SPINAL EXAMINATION

| | Spasm | | Tenderness | | | Articular Fixation | | | Malposition | | |
|------|-------|---|------------|---|---|--------------------|---|---|-------------|---|---|
| | R | L | R | M | L | R | M | L | R | M | L |
| OCC | Ⓞ | Ⓞ | Ⓞ | Ⓞ | Ⓞ | Ⓞ | Ⓞ | Ⓞ | Ⓞ | Ⓞ | Ⓞ |
| C1 | ① | ① | ① | ① | ① | ① | ① | ① | ① | ① | ① |
| C2 | ② | ② | ② | ② | ② | ② | ② | ② | ② | ② | ② |
| C3 | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ |
| C4 | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ |
| C5 | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ |
| C6 | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ |
| C7 | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ |
| T1 | ① | ① | ① | ① | ① | ① | ① | ① | ① | ① | ① |
| T2 | ② | ② | ② | ② | ② | ② | ② | ② | ② | ② | ② |
| T3 | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ |
| T4 | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ |
| T5 | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ |
| T6 | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ | ⑥ |
| T7 | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ | ⑦ |
| T8 | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ | ⑧ |
| T9 | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ | ⑨ |
| T10 | ⑩ | ⑩ | ⑩ | ⑩ | ⑩ | ⑩ | ⑩ | ⑩ | ⑩ | ⑩ | ⑩ |
| T11 | ⑪ | ⑪ | ⑪ | ⑪ | ⑪ | ⑪ | ⑪ | ⑪ | ⑪ | ⑪ | ⑪ |
| T12 | ⑫ | ⑫ | ⑫ | ⑫ | ⑫ | ⑫ | ⑫ | ⑫ | ⑫ | ⑫ | ⑫ |
| L1 | ① | ① | ① | ① | ① | ① | ① | ① | ① | ① | ① |
| L2 | ② | ② | ② | ② | ② | ② | ② | ② | ② | ② | ② |
| L3 | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ | ③ |
| L4 | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ | ④ |
| L5 | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ | ⑤ |
| SAC | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ |
| S-I | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ | Ⓢ |
| COCC | | | Ⓞ | | | Ⓞ | | | Ⓞ | | Ⓞ |

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|--------------------|---|
| OF ADDITIONAL NOTE | ○ |
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| | |
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E. ASSESSMENT

1. CLINICAL IMPRESSION

a. CERVICAL

- 353.0 Brachial Plexus Lesions
- 524.60 TMJ Syndrome
- 721.0 Spondylosis w/o Myelopathy
- 722.0 Disc Displacement w/o Myelopathy
- 722.4 Disc Degeneration
- 723.1 Cervicalgia
- 723.2 Cervicocranial Syndrome
- 723.3 Cervicobrachial Syndrome
- 723.4 Radiculitis
- 729.1 Myalgia / Myofascitis
- 739.1 Segmental/Somatic Dysfunction
- 756.10 Spinal Anomaly
- 784.0 Headache
- 847.0 Sprain/Strain
- Other
- Other

b. THORACIC

- 353.8 Intercostal Neuritis
- 354.8 Other Mononeuritis of Upper Limb
- 721.2 Spondylosis w/o Myelopathy
- 722.11 Disc Displacement w/o Myelopathy
- 722.51 Disc Degeneration
- 724.1 Thoracic Spine Pain
- 724.4 Radiculitis / Neuritis

THORACIC (Continued)

- 729.1 Myalgia / Myosclitis
- 737.10 Kyphosis
- 737.30 Scoliosis
- 739.2 Segmental/Somatic Dysfunction
- 756.10 Spinal Anomaly
- 847.1 Sprain/Strain
- 848.3 Rib/Intercostal Strain
- Other
- Other

c. LUMBOSACRAL

- 721.3 Spondylosis w/o Myelopathy
- 722.10 Disc Displacement w/o Myelopathy
- 722.52 Disc Degeneration
- 724.02 Spinal Stenosis
- 724.2 Lumbago
- 724.3 Sciatica
- 724.4 Radiculitis / Neuritis
- 724.8 Facet Syndrome
- 729.1 Myalgia / Myosclitis
- 739.3 Segmental/Somatic Dysfunction
- 756.10 Spinal Anomaly
- 756.15 Anomaly/Congenital
- 846.0 Sprain / Strain

LUMBOSACRAL (Continued)

- Other
- Other

d. PELVIC

- 715.15 Osteoarthritis
- 724.6 Disorders of Sacrum
- 736.81 Unequal Leg Length (Acquired)
- 738.4 Spondylolisthesis (Acquired)
- 755.30 Shortening of Leg (Congenital)
- 781.92 Abnormal Posture
- 846.1 Sprain/Strain Sacroiliac Ligmt
- Other

e. PERIPHERAL JOINTS

- 726.1 Rotator Cuff/Shoulder Syndrome
- 726.31 Medial Epicondylitis Elbow
- 726.32 Lateral Epicondylitis Elbow
- 840.0 Shoulder Sprain/Strain
- 841.0 Elbow Sprain/Strain
- 844.0 Knee Sprain/Strain
- 845.0 Ankle Sprain/Strain
- Patellofemoral Dysfunction Syndrome
- Other
- Other

2. OF ADDITIONAL NOTE

3. CONSULTATION NOTE FORMAT

- Headache
- Neck Pain
- Neck Pain w/Radiating Upper Extremity Pain
- Mid Back Pain
- Low Back Pain
- Low Back Pain w/Radiating Lower Extremity Pain
- Complete Chiropractic Evaluation

F. PLAN

1. RECOMMENDED MANAGEMENT

a. ADJUSTMENTS

| | Cervical | Thoracic | Lumbo-sacral | Sacro-iliac |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Specific Spinal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Spinal Distractive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. Extremity

b. ADJUNCTIVE PHYSICAL MODALITIES

- Ice
- Moist Heat
- Diathermy
- Spinalator
- Mechanical Traction
- Massage
- Ischemic Compression/Manual Trigger Point Therapy
- Other
- Ultrasound
- Low Volt Galvanic
- High Volt Galvanic Spasm Relieving Current
- Interferential Current
- Russian Stimulation Current

c. SUPPORTIVE EXERCISE PROGRAM

None

- Cervical
- Lumbar
- Scoliosis
- Spinal Rehab
- Other

d. REFERRAL RECOMMENDATIONS (IF PATIENT FAILS TO RESPOND BY INITIAL OR SUBSEQUENT RE-EXAMINATION)

- CT Examination
- MRI Examination
- Electrodiagnosis Evaluation
- Internal Medicine Consultation
- Other
- Neurological Consultation
- Neurosurgical Consultation
- Orthopedic Consultation
- Rheumatologic Consultation

e. OF ADDITIONAL NOTE

2. All general measures associated with condition have been reviewed

3. Potential risks have been described and the patient has acknowledged their understanding of them