


# 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?

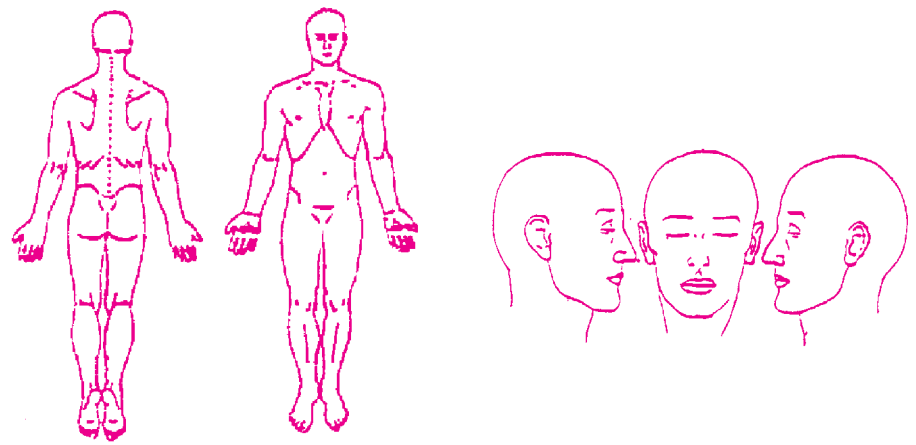
- 10%
- 20%
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%

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

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# 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	1	1
2. Flexion	2	2	2	2	2	2
3. Extension	3	3	3	3	3	3
4. Right Lateral Flexion	4	4	4	4	4	4
5. Left Lateral Flexion	5	5	5	5	5	5

### c. VALSALVA

Positive

Negative

### d. DISTRACTION

Positive

Negative

### e. OF ADDITIONAL NOTE

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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	⑦	⑦	⑦	⑦	⑦	⑦	⑦
Left	⑧	⑧	⑧	⑧	⑧	⑧	⑧

	Positive	Negative
2. Braggard's		
Right	⑨	⑨
Left	⑩	⑩
3. Well Leg Raise		
Right	⑪	⑪
Left	⑫	⑫
4. Lindner	⑬	⑬

##### c. VALSALVA

Positive	Negative
○	○

##### d. KEMP'S

	Right	Left
1. Full And Pain Free	○	○

	Positive	Negative
2. To Right - Pain		
a. Back	⑭	⑭
b. Right Leg	⑮	⑮
c. Left Leg	⑯	⑯
3. To Left - Pain		
a. Back	⑰	⑰
b. Right Leg	⑱	⑱
c. Left Leg	⑲	⑲

##### e. FABERE PATRICK

	Positive	Negative
Right	⑲	⑲
Left	⑳	⑳

##### f. POSTURAL SIGNS

	Positive	Negative
Minor's	㉑	㉑
Adam's	㉒	㉒

	Right	Left	Flexion
Antalgia	○	○	○

##### g. OF ADDITIONAL NOTE

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### D.SPINAL EXAMINATION

	Spasm		Tenderness			Articular Fixation			Malposition		
	R	L	R	M	L	R	M	L	R	M	L
OCC	㉓	㉓	㉓	㉓	㉓	㉓	㉓	㉓	㉓	㉓	㉓
C1	㉔	㉔	㉔	㉔	㉔	㉔	㉔	㉔	㉔	㉔	㉔
C2	㉕	㉕	㉕	㉕	㉕	㉕	㉕	㉕	㉕	㉕	㉕
C3	㉖	㉖	㉖	㉖	㉖	㉖	㉖	㉖	㉖	㉖	㉖
C4	㉗	㉗	㉗	㉗	㉗	㉗	㉗	㉗	㉗	㉗	㉗
C5	㉘	㉘	㉘	㉘	㉘	㉘	㉘	㉘	㉘	㉘	㉘
C6	㉙	㉙	㉙	㉙	㉙	㉙	㉙	㉙	㉙	㉙	㉙
C7	㉚	㉚	㉚	㉚	㉚	㉚	㉚	㉚	㉚	㉚	㉚
T1	㉛	㉛	㉛	㉛	㉛	㉛	㉛	㉛	㉛	㉛	㉛
T2	㉜	㉜	㉜	㉜	㉜	㉜	㉜	㉜	㉜	㉜	㉜
T3	㉝	㉝	㉝	㉝	㉝	㉝	㉝	㉝	㉝	㉝	㉝
T4	㉞	㉞	㉞	㉞	㉞	㉞	㉞	㉞	㉞	㉞	㉞
T5	㉟	㉟	㉟	㉟	㉟	㉟	㉟	㉟	㉟	㉟	㉟
T6	㊱	㊱	㊱	㊱	㊱	㊱	㊱	㊱	㊱	㊱	㊱
T7	㊲	㊲	㊲	㊲	㊲	㊲	㊲	㊲	㊲	㊲	㊲
T8	㊳	㊳	㊳	㊳	㊳	㊳	㊳	㊳	㊳	㊳	㊳
T9	㊴	㊴	㊴	㊴	㊴	㊴	㊴	㊴	㊴	㊴	㊴
T10	㊵	㊵	㊵	㊵	㊵	㊵	㊵	㊵	㊵	㊵	㊵
T11	㊶	㊶	㊶	㊶	㊶	㊶	㊶	㊶	㊶	㊶	㊶
T12	㊷	㊷	㊷	㊷	㊷	㊷	㊷	㊷	㊷	㊷	㊷
L1	㊸	㊸	㊸	㊸	㊸	㊸	㊸	㊸	㊸	㊸	㊸
L2	㊹	㊹	㊹	㊹	㊹	㊹	㊹	㊹	㊹	㊹	㊹
L3	㊺	㊺	㊺	㊺	㊺	㊺	㊺	㊺	㊺	㊺	㊺
L4	㊻	㊻	㊻	㊻	㊻	㊻	㊻	㊻	㊻	㊻	㊻
L5	㊼	㊼	㊼	㊼	㊼	㊼	㊼	㊼	㊼	㊼	㊼
SAC	㊽	㊽	㊽	㊽	㊽	㊽	㊽	㊽	㊽	㊽	㊽
S-I	㊾	㊾	㊾	㊾	㊾	㊾	㊾	㊾	㊾	㊾	㊾
COCC			㊿			㊿			㊿		㊿
OF ADDITIONAL NOTE	○										

**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**