Carlson Wellness Clinic

Re-Examination/Condition Form

Name: ____ Date: ____________________

INSURANCE PATIENTS: PLEASE BE SPECIFIC AND COMPLETE WITH YOUR ANSWERS AS WELLNESS/MATIENENCE CARE IS NOT COVERED BY INSURANCE

What is your main complaint today (describe your condition) ?

____

W**HEN did it begin?**

____

HOW did your condition begin:

____

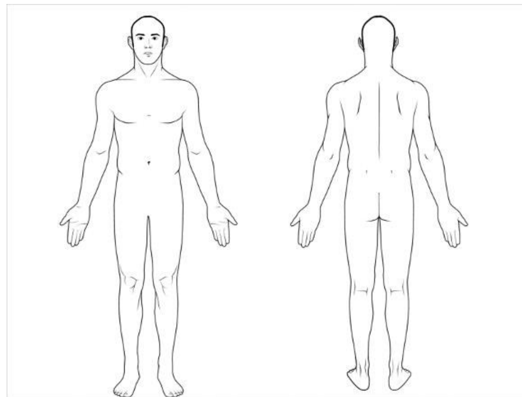
Please rate the severity of your current pain or other primary complaint:

Best

1
2
3
4
5
6
7
8
9
10

Worst

Location (where does it hurt?)
Circle the area(s) on the illustration



Quality of symptoms
(What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other

How often do you experience your current pain or primary complaint?

0 – 25% of the day   26 – 50% of the day   51 -75% of the day   76 – 100% of the day

What aggravates your condition/symptom?

____

What alleviates your condition/symptom?

____

These symptoms negatively impact my ability to:

Work   Sleep   Exercise   Daily Activities

Please list any falls, accidents, or other injuries and medication changes since your last visit.

____

Have you received any other care for this injury? If yes, where and what?

____

It is the office policy at Carlson Wellness Clinic, as well as the policy of insurance companies, that re-examinations need to be performed periodically to determine progress of your condition. Most insurance companies cover this charge, but some do not. By initialing this form, you acknowledge that this fee is your financial obligation if not covered by your insurance company. _______________ **(Initials)**