

DATE _____ DR. _____ PATIENT _____ # _____

SYMPTOMATIC PROGRESS EVALUATION (SPE)

1. Are you benefiting from Chiropractic Care?

Yes

No

Comments or Questions

2. Are you

Improving?

About the same?

Worse?

3. What percentage of improvement have you experienced SINCE YOU BEGAN treatment?

_____ %

4. What things (activities, positions, etc) aggravate your condition?

5. Are you satisfied with your progress?

Yes

No

Maybe

6. Do you need an additional consultation with your treating doctor to discuss your care?

Yes

No

7. Pain scale (make a vertical line at your level of pain)

No symptoms _____ Severe symptoms

Patient Signature: _____

UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Patient Number
(office use only)

Your Last Name _____

Your First Name _____

Your Middle Name (or Initial) _____

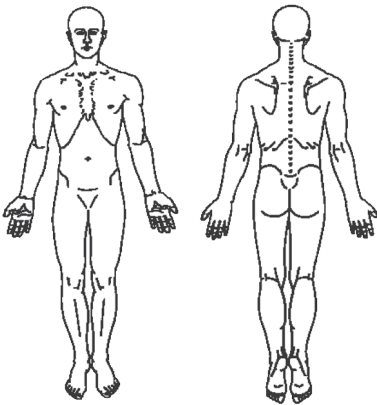
I have new contact information

Please select one:

- Progress evaluation** – I've been under active care and this is a periodic reevaluation.
- New condition** – I've been under care and a new or returning condition has emerged.
- Maintenance patient** – I'm under maintenance care with a new or returning health issue.
- Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

1. Location (Where does it hurt?)
Circle the area (s) on the illustration.



2. Quality of symptoms (What does it feel like?)

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

3. Intensity (How extreme are your current symptoms?)

0 10
Absent Uncomfortable Agonizing

4. Duration and Timing (When did it start and how often do you feel it?)

Constant Come and goes.

When did it start and how often? _____

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

7. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

8. What else should Arlington Chiropractic Clinic know about your current condition? _____

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Endocrine System – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

This updated patient history is for:

- Current Patient
Periodic Re-evaluation
- Current Patient
Additional Complaint/
Exacerbation
- Maintenance Patient (circle one)
Exacerbation
Re-Occurrence
New Episode
- Inactive Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

Consultation Notes

UPDATED PATIENT HISTORY

Doctor's Initials _____

PAGE
1/2

11. Medications (please list all prescription and over-the-counter): _____

Patient name _____

12. Social History (Tell Arlington Chiropractic Clinic about your health habits and stress levels.)

Patient Number
(office use only)

Alcohol use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Prayer or meditation?	<input type="radio"/> Yes	<input type="radio"/> No
Coffee use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Job pressure/stress?	<input type="radio"/> Yes	<input type="radio"/> No
Tobacco use	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Financial peace?	<input type="radio"/> Yes	<input type="radio"/> No
Exercising	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Vaccinated?	<input type="radio"/> Yes	<input type="radio"/> No
Pain relievers	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Mercury fillings?	<input type="radio"/> Yes	<input type="radio"/> No
Soft drinks	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____	Recreational drugs?	<input type="radio"/> Yes	<input type="radio"/> No
Water intake	<input type="radio"/> Daily	<input type="radio"/> Weekly	How much? _____			
Hobbies:	_____					

13. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Is there anything else Arlington Chiropractic Clinic should know about your current condition, your progress or ways your current condition is affecting your life?

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Consultation Notes

Patient (or Guardian's) signature _____

Date (MM/DD/YYYY) _____

Doctor's Initials _____

Arlington Chiropractic Clinic
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