Patient Re-evaluation Form

First Name: ______________________ Last Name: _______________________ M / F
Address: _________________________________ City: _________________ State: ___
Zip Code:____________ E-mail Address: _____________________________________
Date of Birth: ___/___/______ Occupation: ____________________________________
Home Phone: (___) _____-_________ Work Phone: (___) ___-________
Emergency Contact: ____
Relationship: _______________________ Phone Number: (___) _____-_____________
Has your insurance coverage changed since your last patient visit? YES / NO
If yes, what is the name of the new ins company? ________________________________

History

Please describe the area of complaint: ____
____
Is your complaint due to: Accident / Injury at work / Injury at home / Lifting / Falling / Stress / Auto Accident / Sports / Other ________________________
How long has this condition lasted? ____
Date complaint began: ___/___/______ Have you had this before? _________________
How is this affecting your every day activities? _________________________________
____
What are my goals from treatment? ____

Medical Information

Are you currently taking any medication? Y / N Which one(s)? ____________________
____
Do you have any allergies? Y / N please list: ___________________________________
Are you currently under the care of a physician or psychologist? Y / N
Please Indicate: ____
Have you had any surgery since your last visit: Y / N When/Where?
____
Name of Physician: __________________________ Phone Number: (___)___-________

3450 Montgomery Rd / Suite 21 / Aurora, IL 60504 Ph # 630.236.8600 Fax # 630.236.8612
www.spinalrehabcenter.com

Please Check All That Apply Since Last Patient Visit

☐Acne	☐Broken Bones	☐Diarrhea	☐High Cholesterol	☐Paralyses
☐AIDS/HIV	☐Burns	☐Dizziness	☐Insomnia	☐Prosthetics
☐Anemia	☐Cancer/Tumors	☐Epilepsy	☐IUD	☐Pregnant
☐Arteriosclerosis	☐Chronic Bronchitis	☐Fatigue	☐Joint Pain	☐Rash
☐Arthritis	☐Circulatory Problems	☐Fractures	☐Kidney Disease	☐Sinusitis
☐Asthma	☐Constipation	☐Headaches	☐Liver Disorders	☐Skin Problem
☐Athlete's Foot	☐Contact Lenses	☐Hernia	☐Lung Disease	☐Back Pain
☐Back Problems	☐Cuts or Sores	☐Herpes	☐Nervousness Stroke	☐Blood Clots
☐Diabetes	☐High Blood Pressure	☐Ulcers	☐Varicose Veins	☐Bruise easily

I understand the therapy I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session(s), I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that soft tissue work should not be construed as a substitute for medical examination, diagnosis, or treatment. Because soft tissue work should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioners fault should I forget to do so. It is also understood that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for full payment of the session.

Signature: ______________________________ **Date:** ____________________

(Parent/Guardian Signature required if under the age of 18)

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