GROVE
SPINE & SPORTS CARE
CENTER FOR SPORTS INJURIES, CHIROPRACTIC & REHAB

Re-Exam/Update

Today's Date _____
Name_____
Address_____
City_____State _____Zip_____

Home Phone_____
Work Phone_____
Cell Phone_____
Email_____

1. Have you experienced any new injuries or trauma since your last visit? If so, please describe:

_____
_____
_____

2. When did your pain start?

_____
_____

3. Where is your pain?

_____
_____

4. Please rate your overall pain on a scale of 1 to 10:

Less Painful Very Painful

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

5. What activities/sports does your condition prevent at this time?

_____
_____
_____

6. Are you currently taking any over the counter or prescription medication for this condition? If yes, please list:

_____
_____

7. Which of these movements are difficult to perform?

☐WALKING ☐STANDING ☐SITTING ☐STOOPING ☐SLEEPING ☐None

8. Have you seen any other provider's for this? If yes, please explain:

_____
_____
_____

9. Is there anything you think the doctor should know about your condition?

_____
_____
_____

_____
Patient Signature