TOTALBODY
CHIROPRACTIC AND SPORTS THERAPY

RE-EXAMINATION

Name (Please Print) _____ Date _____

Address: _____ Phone #: _____

Email: _____ Age _____ Occupation _____

Where is your major complaint? _____ Right or Left

Please check if applicable: WCB ____ or ICBC ____ Claim #: _____

How Long Have You Had This Pain? Years ___ Months ____ Weeks _____ Days ____

Is This Your First Episode Of This Pain? Yes ____ No ____

Are you on any medications? _____

Any car accidents, fractures or surgeries since your last visit? _____

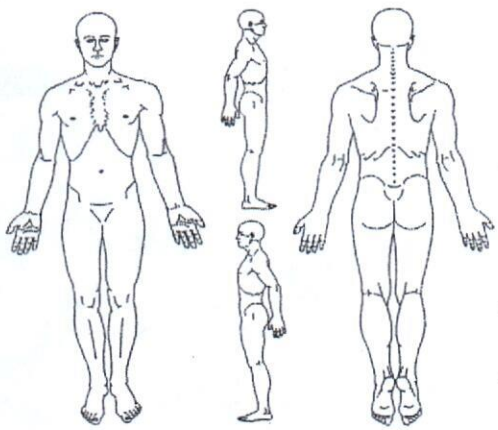
_____

_____

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

KEY: A = ACHE B = BURNING N = NUMBNESS
P = PINS & NEEDLES S = STABBING O = OTHER

Please use the space provided below to describe any medical complaints you are currently experiencing, or for any additional comments you may wish to make regarding your condition.



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For Doctor use: