Robertson Spinal Rehab Associates
Out of injury, back to life

4666 Commercial St SE
Salem, OR 97302
(503) 399-7607
Www.RobertsonSpine.com

Name: **Chart ID**

Date the problem started:___/___/___Describe the reason for today's visit: ______________________________

____

Have you had similar complaints in the past? ☐ Yes ☐ No How long did it last? ______________________.

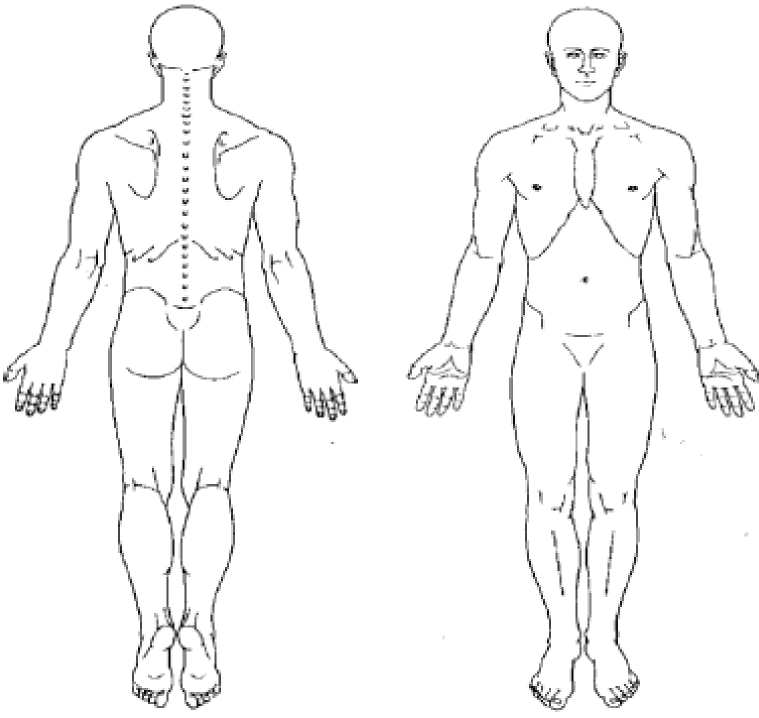
Are your complaints related to ☐ Car Accident ☐ Work Injury ☐ Sports Injury ☐ None

Have you been seen for your current condition ☐ Yes ☐ No Who did you see? ______________________.

What type of treatment did you have? ____.

Have you ever had Chiropractic Care in the past ☐ Yes ☐ No

Please Mark Area(s) of Complaint



Please circle the severity of your complaints (0= no pain, 10=worst pain)

Currently

0 1 2 3 4 5 6 7 8 9 10

Least Painful

0 1 2 3 4 5 6 7 8 9 10

Most Painful

0 1 2 3 4 5 6 7 8 9 10

Describe Current Symptoms

☐ Achy ☐ Sharp ☐ Burning ☐ Dull ☐ Sore ☐ Numb ☐ Shooting ☐ Throbbing ☐ Tingling

How often are symptoms present

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%)

What makes the complaints BETTER

☐ Rest ☐ Ice ☐ Laying Down ☐ Movement ☐ Stretching ☐ Exercise ☐ Heat ☐ Medication ☐ Nothing

What makes the complaints WORSE

☐ Movement ☐ Sitting ☐ Squat ☐ Lifting ☐ Standing ☐ Bending ☐ Twisting ☐ Working ☐ Nothing

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Occupation/Social History

Occupation_________________________________**Employer's Name** __________________________________

Employment ☐ Full ☐ Part ☐ Retired ☐ Student ☐ Unemployed

Job Description ____

Exercise Routine ☐ Light ☐ Moderate ☐ Intense ______Times a week for __________minutes

Alcohol Intake (per week) ☐ Never ☐ Occasional ☐ Daily Number of drinks/week___________

Caffeinated Beverages (per day) ____ Cups of **Coffee** _____Cups of **Tea** _____Cups of **Soda**

Tobacco (per day) ☐ Non– Smoker ☐ Previous smoker (Quit Date _____) ☐ Current Smoker (packs/day____)

Do you use any type of recreational drugs? ☐ Yes ☐ No If yes how often ___________________

Health History

Please Circle ALL that Apply:

Anemia	Bone Fracture	Diabetes	Heart Problems
Dislocated Joints	Dizziness/Fainting	Osteoporosis	HIV/AIDS
Stroke (date__________)	Kidney Trouble	Arthritis	Mental/Emotional Difficulty
High blood pressure	Epilepsy/Seizures	Cancer/Tumor	Pacemaker
Low blood pressure	Birth control pills	Corticosteroid use	Prostate Problems
Visual Disturbances	Aortic Aneurysm	Urinary Retention	Multiple Sclerosis
Spinal Disc Disease	Thyroid Trouble	Tuberculosis	Ulcer
Polio	STDS	Scoliosis	Rheumatic fever

Number of Pregnancies:________Number of Births:_____

Have you ever had: (circle **ALL** that apply)

Chicken Pox Measles Mumps MRSA Staph Cancer Seizures Meningitis

Past Surgeries (type and year) ____

____

Allergies:____

Primary Care Physician:____________________________**Location:**________________**Last Visit:**_________

Current Medications:____

Do you have a Family Chiropractor? ☐ **Yes, Name**__________________________ ☐ **No**

Initial_____**Date**_____

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Family Health History

Please Circle ALL that Apply:

Anemia	Bone Fracture	Diabetes	Heart Problems
Dislocated Joints	Dizziness/Fainting	Osteoporosis	HIV/AIDS
Stroke (date___________)	Kidney Trouble	Arthritis	Mental/Emotional Difficulty
High blood pressure	Epilepsy/Seizures	Cancer/Tumor	Pacemaker
Low blood pressure	Birth control pills	Corticosteroid use	Prostate Problems
Visual Disturbances	Aortic Aneurysm	Urinary Retention	Multiple Sclerosis
Spinal Disc Disease	Thyroid Trouble	Tuberculosis	Ulcer
Polio	STDS	Scoliosis	Rheumatic fever

Type of Cancer: ____

Patient Signature:________________________________ **Date:**___/___/___.

For Office Staff: **Height (stated)** ___________ **Weight** _______. L/R BP ____/______ HR:_______ Handed L/R/A

Any Infections Pacemaker Stents Meds_______________________________

Positive Orthopedic Tests are Circled

C-compression Left (N, Lat L, Lat R, Max L, Max R) Right (N, Lat L, Lat R, Max L, Max R) **C Distraction**

Valsalva **Shoulder Abduction** L / R **Shoulder Depression** L / R **MNTT** L / R **Swallowing**

SLR L / R **Braggard** L / R **Kemps** L / R (LBP) **FABRE** L / R **Iliac Compression / Distraction**

DTR's (2+/2 WNL) **Biceps L / R** **Triceps L / R** **Brachioradialis L / R** **Patella L / R** **Achilles L / R**

Cervical ROM

Flexion ________(50)
Extension ______(60)
R Lat Flex _____(45)
L Lat Flex _____(45)
R Rot _________(80)

Lumbar/ Thoracic ROM

Flexion _____(45/60)
Extension______(25)
R Lat Flex______(25)
L Lat Flex ______(25)
R Rot _________(30)

Manual Muscle Testing scale of 0-5 (5 being WNL)

Hip Flexor	____L / ____R	Deltoids	____L / ____R
Hip ABD	____L / ____R	Biceps	____L / ____R
Hip ADD	____L / ____R	Triceps	____L / ____R
Knee Ex	____L / ____R	Wrist Flex	____L / ____R
Knee Flex	____L / ____R	Wrist Ext	____L / ____R