Robertson Spinal Rehab Associates
Out of injury, back to life

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

Name: **Date of Birth:**

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? _____________________.

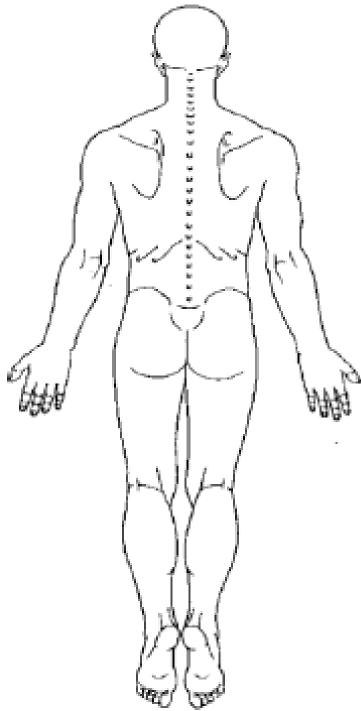
Have you been seen for your current condition ☐ Yes ☐ No Who did you see? ___________________.

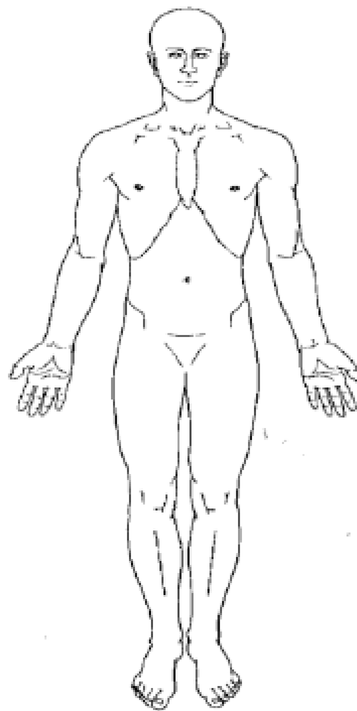
What type of treatment did you have? ____.

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 ☐ Lying 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 / past job duties ____.

Exercise Routine ☐ Light ☐ Moderate ☐ Intense ☐ None__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____)

Any use of Vaping products? ☐ Yes ☐ No If yes how much is used daily _____________

Any use of Recreation Drug use? ☐ Yes ☐ No If yes how often and what kind __________________

YOUR 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	Aneurysm	Urinary Retention	Multiple Sclerosis
Spinal Disc Disease	Thyroid Trouble	Tuberculosis	Ulcer
STDS	Scoliosis	Rheumatic fever	

Number of Births_____

Any other medical health conditions: ____

____

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:____

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Family Health History

Please Circle ALL that Apply:

Anemia	Diabetes	Heart Problems	Ulcer
Fibromyalgia	Dizziness/Fainting	Osteoporosis	Pacemaker
Stroke (date_____)	Kidney Trouble	Arthritis	Mental/Emotional Difficulty
High blood pressure	Epilepsy/Seizures	Cancer/Tumor	Scoliosis
Low blood pressure	Corticosteroid use	Prostate Problems	HIV/AIDS
Aortic Aneurysm	Urinary Retention	Multiple Sclerosis	Rheumatic fever
Spinal Disc Disease	Thyroid Trouble	Tuberculosis	Autoimmune Disorder

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 (N, Lat L, Lat R, Max L, Max R) **C Distraction** **Shoulder Abduction** L / R **Shoulder Depression** L / R

Valsalva **MNTT** L / R **Swallowing** **Heel/Toe Walk** **Squat and Recovery** **AP/Lateral Compression**

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

DTR's (2+/2 WNL) Upper ____**Lower** ____ **Sensation Upper** _____ **Lower** ____ **Vibration Upper** ____**Lower** ___

Cervical ROM	**Lumbar/ Thoracic ROM**
Flexion ________(50)	Flexion ______(45/60)
Extension ______(60)	Extension______(25)
R Lat Flex ______(45)	R Lat Flex______(25)
L Lat Flex ______(45)	L Lat Flex ______(25)
R Rot ________(80)	R Rot ________(30)
L Rot________(80)	L 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
Dorsal Ft ____L /____R	Fingers ____L /____R