Scoma Chiropractic, P.A.

Dr. Louis Scoma

1113 SE 47TH Terrace, unit 1 Cape Coral, Florida 33904
Phone: (239) 945-1717 Fax: (239) 945-1963

Health and Wellness Center

SHORT- & LONG-TERM GOALS

Name: _____ Date: _____

A. SHORT TERM GOALS:

1. _____
2. _____
3. _____

B. LONG TERM GOALS:

1. _____
2. _____
3. _____

_____
Patient Signature

_____

Dr. Signature

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HOURS BY APPOINTMENT

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QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please put a mark on the line that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

1. What is your pain RIGHT NOW?

no pain _____ worst possible pain

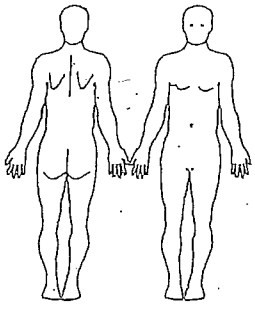
2. What is your TYPICAL or AVERAGE pain?

no pain _____ worst possible pain

What is your pain level AT ITS WORST?

no pain _____ worst possible pain

Mark the diagram as follows:
A - Ache
B - Burning
N - Numbness
P - Pins & Needles
S - Stabbing
O - Other - Describe



NAME _____ AGE_____ DATE_____

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Questionnaire

Name: _____ Date: _____ Age: _____

Please check the appropriate response. If "yes," please explain. If you are not sure, check the "?" box.

No	Yes	?	
☐	☐	☐	Do you have a history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Are you 50 years or older?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain for more than 4 weeks?
☐	☐	☐	Does your pain improve with rest?

No	Yes	?	
☐	☐	☐	Prolong use of corticosteroids (such as organ transplant Rx)?
☐	☐	☐	Intravenous drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	☐	Immunosuppressant medication and/or condition?

No	Yes	?	
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person > 50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any prolonged use of corticosteroids?

No	Yes	?	
☐	☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)
☐	☐	☐	Loss of anal sphincter tone (bowel accidents)
☐	☐	☐	Saddle anesthesia (numbness in the groin area)
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)

No	Yes	?	
☐	☐	☐	Are you a smoker or have you ever smoked?
☐	☐	☐	Are you a male?
☐	☐	☐	Is your race white?
☐	☐	☐	Do you have a family history of aneurysms?

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No	Yes	?	
☐	☐	☐	Do you have band-like trunk pain?
☐	☐	☐	Do you have vague, non-specific symptoms in your legs (i.e. heaviness)?
☐	☐	☐	Do you have decreased mobility?

No	Yes	?	
☐	☐	☐	Do you have any dizziness or numbness?
☐	☐	☐	Are you having problems with your vision?
☐	☐	☐	Are you having any difficulty speaking or swallowing?
☐	☐	☐	Are you having any difficulty walking?
☐	☐	☐	Are you experiencing any nausea or vomiting?
☐	☐	☐	Are you experiencing pain unlike anything you have felt before?

Comments: _____

_____

_____

_____

_____

_____

Patient's signature: _____ Date: _____