Patient Follow-Up Packet

Name:___________________________________ Date:____/____/________

This packet should be completed every two weeks and given to Dr. Ken Gilden.

858-576-0575

5450-F Clairemont Mesa Blvd.
San Diego, CA 92117

1208 North 2nd. Street
El Cajon, CA 92021

Gilden Family Chiropractic

Follow-Up Evaluation

Restrictions of Daily Activates

Name:____ Date:_____/_____/_________

It is very important to document the restrictions you have in your daily life since the accident. Please fill out any of the following activates that you are experiencing difficulty and add any additional activates that are not listed in the blanks below.

Activities And Body Movements	Performance Level 0 to 10 0= Unable To Do 10=No Restriction	Pain Level 0 to 10 0=No Pain 10=Intense Pain	Additional Comments
Driving			
Exercising			
Walking			
Working			
Sleeping			
Sitting			
Standing			
Shaving			
Neck Bending			
Neck Rotation			
Mid Back Bending			
Mid Back Rotation			
Low Back Bending			
Low Back Rotation			

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Follow-Up Evaluation

Head Trauma/Pain List

Name:____ Date:_____/_____/_________

General Location/Item	Specific Location/Item	Pain Level 0=No Pain 10=Intense	Describe The Pain/Item	Duration Of Pain/Item	Time Of Day
Headache					
Dizziness					
Nausea					
Vertigo					
Ringing In Ears					
Loss Of Hearing					
Ear Discharge					
Loss Of Eye Sight					
Seeing Things					
Pain Around eyes					
Light Sensitive					
Loss Of Smell					
Nasal Discharge					
Nose Pain					
Face Flushed					
Face Pain					
Memory Loss					
Balance Loss					
Fainting					
Fatigue					
Depression					
Confusion					
Irritable					
Difficulty Talking					
Change Of Taste					
Sleep Disturbances					

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Follow-Up Evaluation

Body Trauma/Pain List

Name:____ Date:_____/_____/_________

General Location	Specific Location	Pain Level 0=No Pain 10=Intense	Describe The Pain (Sharp, Dull)	Duration Of The Pain	Time Of Day
Upper Neck					
Lower neck					
Upper Back					
Middle Back					
Lower Back					
Lt. Hip					
Rt. Hip					
Lt. Shoulder					
Rt. Shoulder					
Lt. Arm					
Rt. Arm					
Lt. Hand					
Rt. Hand					
Lt. Thigh					
Rt. Thigh					
Lt. leg					
Rt. Leg					
Lt. Foot					
Rt. Foot					
Radiating Pain					

Signed ____ **Date** ____________

Legal Guardian (if applicable) ___________________________ **Date** ____________