

FOLLOW-UP FORM

Patient Name: _____

DEMOGRAPHICS

Primary Care Physician _____

List other treating physicians: _____

Referring Physician: _____

REASON FOR TODAY'S VISIT

What specifically do you want to accomplish with today's visit? _____

CURRENT MEDICATIONS (Include doses, and all over the counter medications and herbal supplements)

NEW MEDICAL PROBLEMS, SURGERIES, OR ALLERGIES

What tests have you had since your last visit? (Circle)

X-ray CT-Scan MRI EMG Other None

SOCIAL HISTORY

Occupation: _____ Status: (Circle One) Full-time / Part-time / Restricted-Duty / Off-Duty to Injury / Retired / Not working

Last Date of Employment: _____

PAIN HISTORY

Quality (circle all that apply): dull /sharp /stabbing /burning /achy /throbbing /shooting/ squeezing/pressure/crampy

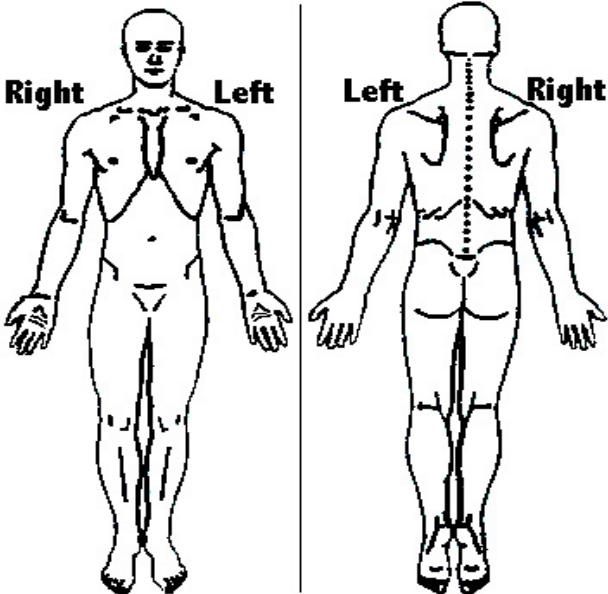
Using the pain scale below, please rate how bad your pain is today:



0 1 2 3 4 5 6 7 8 9 10
 No Pain Mild Pain Mod Pain Severe Pain Very Severe Worst Possible

Since your last visit, do you feel...?
 (Draw one mark on line below)

100% Worse 0% Same 100% Better



Treatments you have tried since your last visit:
 (Circle helpful ones and cross-out unhelpful ones)

- Physical therapy Acupuncture Chiropractor
 Home exercises Injections Counseling
 TENS Unit Massage Braces
 Other _____

Have you ever had?

Yes No

Difficult swallowing, headaches		
Chest pain, palpitations		
Shortness of breath, asthma		
Nausea, vomiting, black stools		
Loss of bowel or bladder control		
Urinary or prostate/gynecologic issues		
Rashes		
Dizziness, weakness, numbness, tingling		
Depression, sleep problems		
Prior musculoskeletal problems		
Easy bleeding, on blood thinners		

Patient Signature _____

Date: _____

Reviewing Physician Initials: _____

Dictation #:

Attending Physician Note: