

Patient Follow-Up Form

Name: _____

Have any of the following changed since our last visit: (check one)

- | | | |
|---|------------------------------|-----------------------------|
| *Medical condition/Hospitalization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *New Diagnostic Studies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Employment Status/restrictions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Involved in any new accident/incident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Date of Birth: _____

Date of Service: _____

Are you currently receiving or performing any of the following treatments: (circle one)

- | | | |
|------------------------------|------------------------------|-----------------------------|
| *TENS/Interferential Current | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Acupuncture | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Massage Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Physical Therapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Chiropractic care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| *Independent Exercises | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, facility name: _____

If yes, facility name: _____

If yes, facility name: _____

If yes, facility name: _____

If you recently have been participating in rehab / therapy, how much relief would you say you received? _____ % (0-100%)

If you recently had a procedure, how much relief did you receive compared to pre-procedure? _____ % (0-100%)

Please answer the following about your pain:

1. Which position **INCREASES** your pain? No changes since last visit

- | | | | | | |
|--|--|---|--|--|--------------------------------------|
| <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Reaching | <input type="checkbox"/> Walking | <input type="checkbox"/> Moving Around | <input type="checkbox"/> Lying on Lt. Side | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bending Backwards | <input type="checkbox"/> Sitting | <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Rotation | <input type="checkbox"/> Lying on Rt. Side | _____ |
| <input type="checkbox"/> Lying on Back | <input type="checkbox"/> Standing | <input type="checkbox"/> Increased Activity | <input type="checkbox"/> Coughing | <input type="checkbox"/> Rehab / Therapy | _____ |
| <input type="checkbox"/> Lying on Stomach | <input type="checkbox"/> Weightbearing | <input type="checkbox"/> Working | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Recent Procedure | _____ |

2. Which position **REDUCES** your pain? No changes since last visit

- | | | | | | |
|--|--|---|--|--|--|
| <input type="checkbox"/> Bending Forward | <input type="checkbox"/> Reaching | <input type="checkbox"/> Walking | <input type="checkbox"/> Moving Around | <input type="checkbox"/> Lying on Lt. Side | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Bending Backwards | <input type="checkbox"/> Sitting | <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Rotation | <input type="checkbox"/> Lying on Rt. Side | <input type="checkbox"/> Ice |
| <input type="checkbox"/> Lying on Back | <input type="checkbox"/> Standing | <input type="checkbox"/> Increased Activity | <input type="checkbox"/> Coughing | <input type="checkbox"/> Rehab / Therapy | <input type="checkbox"/> Brace / Support |
| <input type="checkbox"/> Lying on Stomach | <input type="checkbox"/> Weightbearing | <input type="checkbox"/> Working | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Recent Procedure | <input type="checkbox"/> Other _____ |

Please list any additions or discontinuations of medications since your last visit: _____

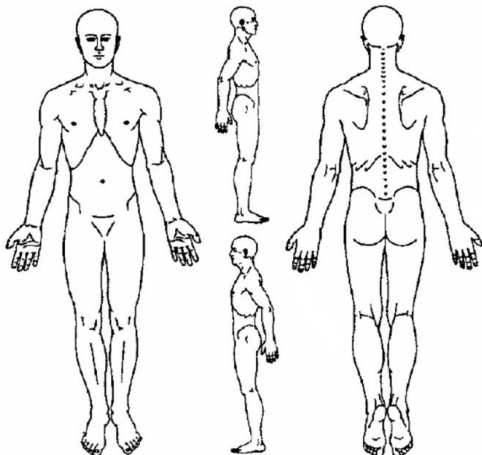
Pain Diagram

Please mark the figure with the location of your symptoms. Do not use circles.

Pain = x x x x

Numbness/Tingling = # # # #

No changes since last visit



Pain Scores (Scale of 0 - 10)

0 = No Pain ———> 10 = The most pain you have ever felt in your life

No changes since last visit

CURRENT pain level (today / now): _____

HIGHEST pain level over the last week: _____

LOWEST pain level over the last week: _____

Characteristic(s) of pain No changes since last visit

(Check all that apply)

- DULL
- ACHING
- BURNING
- SHARP
- SHOOTING
- THROBBING
- SPASMS
- OTHER: _____



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Patient Name: _____ Room # _____

Please check off any of the following symptoms you have been recently experiencing:

No changes since last visit

- General:** Chills Fever Weight Gain Weight Loss
- Skin:** New Lesions Rash Hair Loss Itching
- HEENT:** Blurred Vision Double Vision Hearing Loss Discharge
- Respiratory:** Cough Wheezing Shortness of Breath Sputum
- Cardiovascular:** Chest Pain Abnormal Blood Press. Palpatations Arrhythmia
- Gastrointestinal:** Abdominal Pain Constipation Nausea Vomiting
- Muskuloskeletal:** Neck Pain Dec. Range of Motion Joint Pain Muscle Pain
- Mid-Back Pain Swelling of Extremities Joint Stiffness Muscle Spasms
- Low-Back Pain Deformities Joint Swelling Fatigue
- Neurological:** Headaches Fainting Unsteadiness Numb/Tingling
- Head Injury Poor Coordination Stroke Weakness
- Trouble Walking Incontinence
- Psychiatric:** Anxiety Depression Flashbacks PTSD
- Endocrine:** Cold Intolerance Heat Intolerance Excessive Sweating Diabetes
- Hematology:** Blood Clots Abnormal Bleeding Easy Bruising Blood Thinners
- Genito-Urinary:** Bleeding Discharge Urinary Incontinence UTI

None of the Above Apply

STOP – DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

Last Office Visit: _____ Surgery Date: _____