

Follow-Up Intake Form

Last Name First Name Appointment Date What Dr. are you seeing today?

CC: Chief complaint: What is the reason for this visit?

Location: What is the location of your injury? Check all that apply

- Spine/Back Neck R Shoulder L Shoulder R Arm L Arm R Elbow L Elbow L Wrist R Wrist
R Hand L Hand R Hip L Hip Toes Finger Pelvis Chest Ribs Clavicle R Leg
L Leg R Knee L Knee R Ankle L Ankle R Foot L Foot Other:

RELATED TREATMENT:

What tests/scans have you had since your last visit? X-Ray MRI CT Scan Bone Scan Nerve Test (EMG/NCV)
If you did, where?

QUALITY:

What type of pain do you have? Burning Diffuse Dull/Aching Localized Radiating Sharp
Shooting Stabbing Throbbing Tightness Tingling
What is your level of pain when active? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe
What is your level of pain at rest? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe
What is your severity of pain today? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe

DURATION:

How long have you had your pain? 1 2 3 4 5 6 7 8 9 10 11 12 Hours / Days / Weeks / Months / Years

FOLLOW-UP QUESTIONS:

Have you had any of these since your last visit? Injections Brace/s Physical Therapy Surgery No Surgery

HELPFUL TREATMENTS: Have you had any of these treatments since your last visit? Check all that apply

- Physical Therapy Chiropractic Care Acupuncture Massage Therapy Home Exercise Medication Bracing
Epidural Steroid Injections Facet Block Injections SI Joint Injections

NON HELPFUL TREATMENTS: Have you had any of these treatments since your last visit? Check all that apply

- Physical Therapy Chiropractic Care Acupuncture Massage Therapy Home Exercise Medication Bracing
Epidural Steroid Injections Facet Block Injections SI Joint Injections

Current Work Status: Please answer this question, if you are a Workers Compensation patient.

- Regular Duty Light Duty Not working due to this injury Disabled Retired Student

Have there been any NEW "NON Orthopedic" conditions/problems since your last visit? Yes No

If yes, please list:

Vitals: What is your height and weight? Height: Ft Inches Weight: lbs oz

If you are here today to receive test results, please check off which ones: MRI CT BONE SCAN EMG

MEDICATIONS: Please list current medications and doses. Please mark any medications with an "X" that you need refills on.

Medication list area with lines for writing.