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Patient Follow-Up Form

Name:_____

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

Date of Birth: _____

Date of Service: _____

*Medical condition/Hospitalization	☐ Yes	☐ No
*New Diagnostic Studies	☐ Yes	☐ No
*Employment Status/restrictions	☐ Yes	☐ No
*Involved in any new accident/incident?	☐ Yes	☐ No

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

*TENS/Interferential Current	☐ Yes	☐ No	
*Acupuncture	☐ Yes	☐ No	If yes, facility name: _____
*Massage Therapy	☐ Yes	☐ No	If yes, facility name: _____
*Physical Therapy	☐ Yes	☐ No	If yes, facility name: _____
*Chiropractic care	☐ Yes	☐ No	If yes, facility name: _____
*Independent Exercises	☐ Yes	☐ No	

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*

☐ Bending Forward	☐ Reaching	☐ Walking	☐ Moving Around	☐ Lying on Lt. Side	☐ Other _____
☐ Bending Backwards	☐ Sitting	☐ Changing Positions	☐ Rotation	☐ Lying on Rt. Side	
☐ Lying on Back	☐ Standing	☐ Increased Activity	☐ Coughing	☐ Rehab / Therapy	
☐ Lying on Stomach	☐ Weightbearing	☐ Working	☐ Sneezing	☐ Recent Procedure	

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

☐ Bending Forward	☐ Reaching	☐ Walking	☐ Moving Around	☐ Lying on Lt. Side	☐ Heat
☐ Bending Backwards	☐ Sitting	☐ Changing Positions	☐ Rotation	☐ Lying on Rt. Side	☐ Ice
☐ Lying on Back	☐ Standing	☐ Increased Activity	☐ Coughing	☐ Rehab / Therapy	☐ Brace / Support
☐ Lying on Stomach	☐ Weightbearing	☐ Working	☐ Sneezing	☐ Recent Procedure	☐ Other _____

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

_____

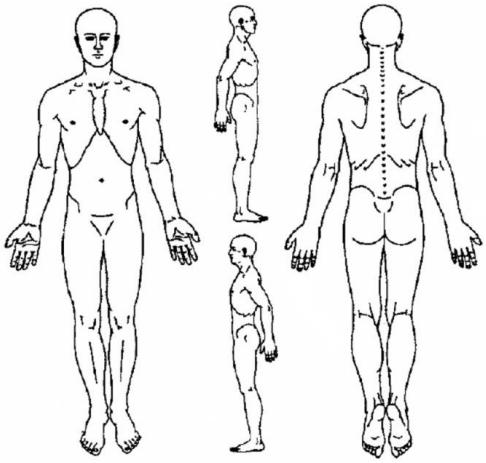
_____

Pain Diagram

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

Pain = ✖ ✖ ✖ ✖
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:** _____

INTERVENTIONAL SPINE CARE & ORTHOPEDIC REGENERATIVE EXPERTS

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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: _____