

## Established Paperwork – Follow Up

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Current Pain Complaint/Reason you are here today: \_\_\_\_\_  
\_\_\_\_\_

Have You Recently Attended Physical Therapy: \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you Currently Working: Yes \_\_\_\_\_ If Yes, job title/duties: \_\_\_\_\_

Yes, With Restrictions \_\_\_\_\_ No \_\_\_\_\_ Disabled \_\_\_\_\_ Retired: \_\_\_\_\_

### MEDICAL HISTORY

Heart Disease  Yes  No

Arthritis  Yes  No

Osteoporosis  Yes  No

Asthma  Yes  No

Thyroid Disorder  Yes  No

Stomach Ulcers  Yes  No

High Blood Pressure  Yes  No

Sleep Apnea  Yes  No

Seizures  Yes  No

Stroke  Yes  No

Kidney Disease  Yes  No

Depression/Anxiety  Yes  No

High Cholesterol  Yes  No

COPD  Yes  No

Reflux/Heartburn  Yes  No

Alcoholism/Drug  
Addiction  Yes  No

Liver Disease  Yes  No

HIV/AIDS  Yes  No

Diabetes  Yes  No

Bleeding  
Disorder  Yes  No

\_\_\_\_\_  
Cancer  Yes  No - If Yes, Please list: Type: \_\_\_\_\_

Autoimmune  
Disorder  Yes  No - If Yes, Please list: Type: \_\_\_\_\_  
\_\_\_\_\_

**Other:** \_\_\_\_\_  
\_\_\_\_\_

Have you had any new surgeries SINCE your last visit: \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes: What surgery & when: \_\_\_\_\_

## Medication List

This form has to be completed/updated at every visit. PLEASE **DO NOT** write "same as last visit".

Please list actual drug name (example: Lisinopril) –do not write "blood pressure medication"  
And list ALL medications INCLUDING over the counter, prescribed by our office or by another physician.

\*\*\*If you brought a list with you, we are happy to copy that instead.

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Medication:

Do you take this medication Daily:

_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed
_____	Yes	No	As Needed

Have you used prescription medications that are **NOT** prescribed to you in the last 30days?

YES NO If Yes, Please List: \_\_\_\_\_

Have you used recreational or illegal drugs in the last 30 days:

YES NO If Yes, Please List: \_\_\_\_\_

Todays Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

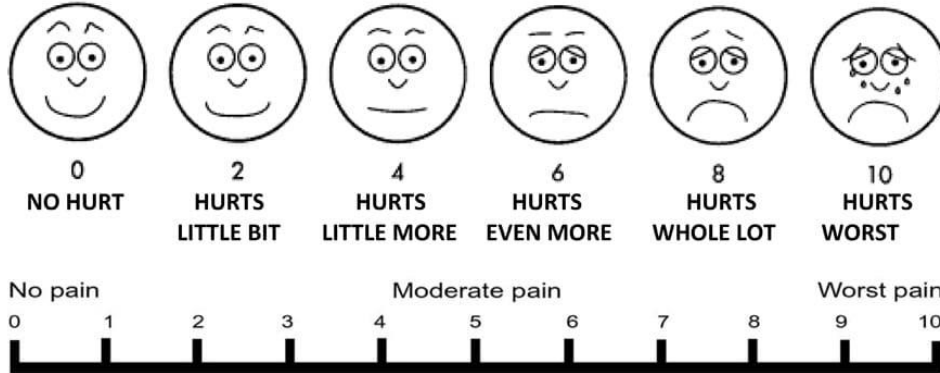
**Conditions that CURRENTLY apply to you:**

<b><u>Constitutional</u></b>			<b><u>Respiratory</u></b>		
Fever (unexplained)	Y	N	Pneumonia	Y	N
Chills	Y	N	Asthma	Y	N
Night Sweats	Y	N	Emphysema	Y	N
Weight Loss (unexplained)	Y	N	Bronchitis	Y	N
Weight Gain (unexplained)	Y	N			
Fatigue	Y	N			
<b><u>ENT</u></b>			<b><u>Gastrointestinal</u></b>		
Loss of Hearing	Y	N	Abdominal Pain	Y	N
Sinus Problems	Y	N	Blood in Stool	Y	N
Tooth/Gum Trouble	Y	N	Nausea/Vomiting (not due to flu)	Y	N
Ringing in Ears	Y	N	Indigestion/Heartburn	Y	N
			Stomach Ulcers	Y	N
			Irritable Bowel Syndrome	Y	N
<b><u>Psychiatric</u></b>			<b><u>Miscellaneous</u></b>		
Depression	Y	N	History of Alcohol Abuse	Y	N
Sleeping Disorder	Y	N	History of Drug Abuse	Y	N
Anxiety	Y	N	Hepatitis	Y	N
Bipolar	Y	N	Liver Disorder	Y	N
<b><u>Cardiovascular</u></b>			<b><u>Genitourinary</u></b>		
Heart Attack	Y	N	Bladder Problems	Y	N
Mitral Valve Prolapse	Y	N	Frequent Urinary Infection(s)	Y	N
Abnormal Heart Rhythm	Y	N	Blood in Urine	Y	N
High Blood Pressure	Y	N	Kidney Stones	Y	N
Stroke / Mini-Stroke	Y	N	History of Kidney Disease	Y	N
Chest Pain	Y	N	Sexual Dysfunction	Y	N
Leg Pain with Exercise- heart	Y	N	Difficulty Urinating	Y	N
Raynaud's Disease	Y	N	Painful Urination	Y	N
<b><u>Musculoskeletal</u></b>			<b><u>Neurological</u></b>		
Low Back Pain	Y	N	Dizzy Spells	Y	N
Mid Back Pain	Y	N	Seizures or Convulsions	Y	N
Neck Pain	Y	N	Headaches	Y	N
Osteoporosis	Y	N	Multiple Sclerosis	Y	N
Joint Swelling	Y	N	Tingling / Numbness	Y	N
Weakness	Y	N	Memory Loss	Y	N
Leg Pain	Y	N	Coordination Loss	Y	N
<b><u>Hematology</u></b>			<b><u>Endocrine</u></b>		
HIV/AIDS	Y	N			
Anemia	Y	N	Diabetes	Y	N
Blood Clots	Y	N	Thyroid Dysfunction	Y	N
Sickle Cell	Y	N	Gout	Y	N

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

CIRCLE the Number that reflects your pain score today.



Use the appropriate Letters shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, including areas where your symptoms radiate.

**Letter B** = Burning    **Letter N** = Numbness    **Letter T** = Tingling    **Letter A** = Ache    **Letter S** = Stabbing

