

Follow-up Visit Intake Paperwork

Please carefully complete all sections of this form, even if nothing has changed since your last visit.

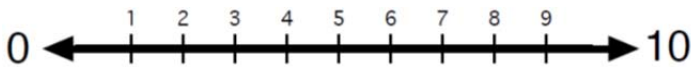
Your Name: _____ Date of Birth: _____ Today's Date: _____
Has your medical coverage changed from your last visit? Yes No

Reason For Today's Visit

- Medication Refill Medication Change Post-Procedure Assessment Review MRI Results
 Review Test Results Other: _____

Pain Description

Height: _____ Weight: _____



Please rate your pain using a 0 – 10 scale:

- _____ Your pain **right now**?
_____ Your **worst pain**?
_____ Your **least pain**?
_____ Your **average pain over the last month**?

Where is your worst area of pain located?

Does this pain radiate? If so, where?

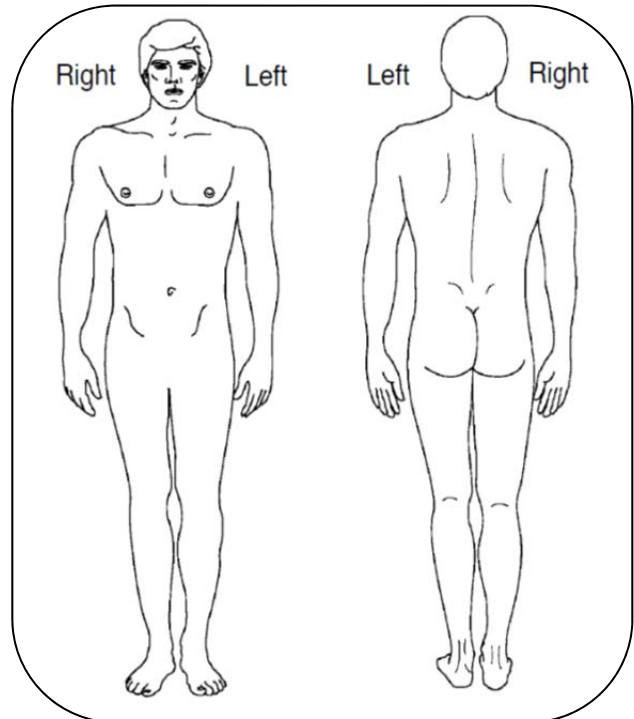
Check all that describe your pain today:

- Aching Shooting
 Cramping Spasming
 Dull Squeezing
 Tingling/Pins and Needles
 Hot/Burning Tiring/Exhausting
 Numb Stabbing/Sharp
 Shock-like Throbbing

Use the diagram to indicate the location and type of your pain.

Mark the drawing with the following letters that best describe your symptoms:

- “N” = numbness “P” = pins and needles
“A” = aching “S” = stabbing “B” = burning



What word best describes the frequency of your pain? Constant Intermittent

When is your pain at its worst? Mornings During the day Evenings Middle of the night

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Chills | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Unexplained Weight Gain | <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Unexplained Weight Loss | | | <input type="checkbox"/> Weakness |

Eyes:

- Recent Visual Changes

Ears/Nose/Throat/Neck:

- | | | | |
|-------------------------------------|---|--|---|
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Earaches | <input type="checkbox"/> Hearing Problems |
| | <input type="checkbox"/> Recurrent Sore Throats | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Sinus Problems |

Cardiovascular:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Shortness of Breath During Sleep | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Lightheadedness |
| | | <input type="checkbox"/> Swelling in the Feet | |

Respiratory:

- | | | | |
|---|--------------------------------|--|---|
| <input type="checkbox"/> Shortness of Breath on Exertion/Effort | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pulmonary Embolism |
| | | <input type="checkbox"/> Shortness of Breath at Rest | |

Gastrointestinal:

- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Coffee Ground Appearance in Vomit | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dark and Tarry Stools | <input type="checkbox"/> Diarrhea |

Musculoskeletal:

- | | | | |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Stiffness |
| | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Neck Pain | |

Genitourinary/Nephrology:

- | | | |
|--|---|--|
| <input type="checkbox"/> Decreased Urine Flow/Frequency/Volume | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Painful Urination |
| | <input type="checkbox"/> Flank Pain | |

Neurological:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Dizziness |
| | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Instability When Walking |
| | | <input type="checkbox"/> Tremors |
| | | <input type="checkbox"/> Seizures |

Psychiatric:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Feeling Anxious | <input type="checkbox"/> Stress Problems |
| | <input type="checkbox"/> Suicidal Planning | | |

Signature and Date

Signed: _____

Date: _____