Follow Up Form Name _______________________ Birth Date _____________

Today's Date _______/________/________

Current Treatments: ☐ Physical Therapy ☐ Massage ☐ Chiropractic
☐ Other____
Provider(s) and Response: ____

If you had an **injection** since your last visit, did it help?
Injection Type   Immediate (hours) Relief?   Long Term (days/wks) Relief?
___________________   Yes / No   Yes / No
Is it still helping?   Yes / No

Any new tests? ☐ X-rays ☐ MRI ☐ CT scan
Location of imaging: ________________________________

Have you seen another doctor since your last visit? Yes / No
Explain: ____

If Neck Pain / Arm Pain, please mark below which is worse

|_____________________________|_____________________________|

100% Neck Pain   50% neck pain / 50% arm pain   100 % Arm Pain
Right or Left

If Low Back Pain/ Leg Pain, please mark below which is worse

|_____________________________|_____________________________|

100% Back Pain   50% back pain / 50% leg pain   100 % Leg Pain
Right or Left

What activities increase your pain?
☐ Standing   ☐ Walking   ☐ Changing Positions
☐ Sitting / Driving   ☐ Lying Down

Do you ever experience a catch or shift in your neck / back?   Yes / No
Have you lost control over your bowel or bladder function?
☐ no   ☐ yes, describe ______________________

I also have:
☐ Balance problems   ☐ Leg / foot weakness/numbness/tingling
☐ Hand clumsiness   ☐ Hand weakness/tingling/numbness
☐ None of these
Do you have pain or tingling at night? Yes / No

What are **three** things in your life that you can't do, or have difficulty doing, because of your pain, and which most dearly would you want restored? *These should be simple, realistic, daily life improvements that other people can see most of the time.*

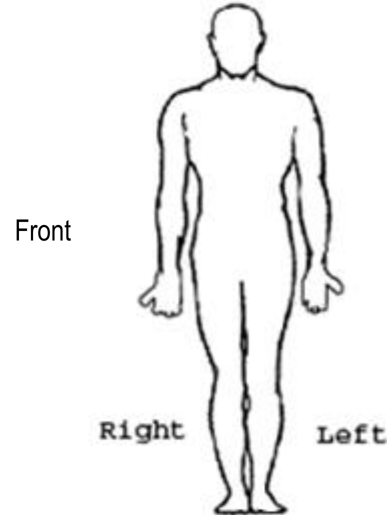
Activity	Restored
1. ______________________________	No A Bit A Lot Completely
2. ______________________________	No A Bit A Lot Completely
3. ______________________________	No A Bit A Lot Completely

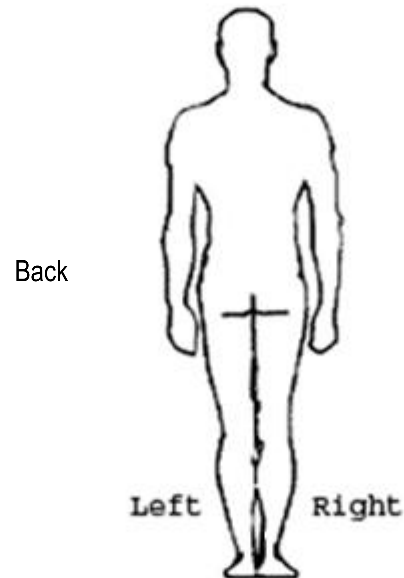
What level of pain would allow you to do your desired activities?

Goal Pain: 0 1 2 3 4 5 6 7 8 9 10

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

Aching * * *
Numbness = = =
Pins and needles O O O
Burning X X X
Stabbing / / /





Please rate your pain by circling the number that best describes your average pain in the last 24 hours on a 0 (no pain) to 10 (pain as bad as you can imagine) scale.

24 Hr. Avg. 0 1 2 3 4 5 6 7 8 9 10

Please complete BOTH sides of this form

Follow Up Form   Name ______________________ Birth Date ____________

Current Medications including over-the-counter medications and supplements:

Medication type   Strength   Actual # taking / day   Results (does it help?)

____
____
____
____
____
____
____

Medications **previously** tried for pain:

See medication list. Any changes in pain meds? Yes / No

Any side effects? Check all that apply: ☐ Sedation ☐ Mental fogginess ☐ Irritability ☐ Sadness ☐ Anxiety ☐ Low energy ☐ Constipation ☐ Other: ____________________

How many times in the past year have you used an illegal drug or used a prescription medication for non- medical reasons? Never / 1 or more times

Work Status: Please check those that apply
☐ Working; Full-time ☐ Working; Part-time ☐ Unable to work ☐ Seeking work ☐ Home Duties ☐ Permanently Disabled ☐ Retired
Does this represent your pre-injury work status? Yes / No

Office Use Below:

Images: ____
____
____
____

PE:

Diagnoses:

_____________________ _____________________
_____________________ _____________________
_____________________ _____________________

Plan:

____
____
____
____
____
____
____
____
____
____

Have you recently had any of the following symptoms? Check all that apply **or check none at the bottom**:

☐ Anxiety or Depression
☐ Fever
☐ Night sweats
☐ Weight loss
☐ Rash
☐ Vision changes
☐ Ringing of the ears
☐ Swelling
☐ Wheezing or breathing problems
☐ Chest pain
☐ Stomach pain
☐ Loss of bowel control
☐ Problems with urination
☐ Pain/cramping in the legs with exertion
☐ Poor Balance
☐ Problems thinking or remembering
☐ **None**

Office Use:

CPDMP consistent? Yes No
U/A consistent? Yes No
80305

Z79.891 (opioid)
Z79.899 (other med / opioid dep)
96103
99202 99203 99204 99205

99211 20552 20553
99212 20610 20611
99213 20605 20606
99214 95886 EMG 5+ Units__
99215 95909 NCV 5-6
959__
95911 NCV 9-10
76942 76881 76882
Modifier: E/M-25 50 - bilateral

FU: ____days ____wks ____mo
FU: JSB__ DT__ JR__ SB__

Procedure? _______________
Referral? ________________

Height (in): ___________Weight (lbs): __________ Reviewed by: __________________________, MD / DO / PA Date____________