Follow-up Patient Intake Form

Name: _____

Date of Birth: _____

What is your primary complaint today?

_____

What are your goals for today's visit?

_____

Since your last visit, do you feel…?

100% Worse **0% Better** **100% Better**

Have you had any other medical, social or family changes since we last saw you? ☐ Yes ☐ No
Please explain:

_____

Any diagnostic tests since your last visit? ☐**No**
☐ X-Ray ☐ CT scan ☐ MRI ☐ EMG ☐ Other
Date(s) of tests(s):_____
Where done: _____

Any new treatments since last visit? ☐**No**
☐ Physical Therapy ☐ Home exercises
☐ Chiropractor ☐ Injection/Nerve blocks
☐ Acupuncture Type: _____
☐ Psychological counseling ☐ Massage
☐ Other_____ ☐ TENS Unit

Any medication changes? ☐ **No** ☐ **Yes**

NAME	DOSE	FREQUENCY

Description:
Is your pain: ☐ constant ☐ intermittent

What makes your pain better?

_____

What makes your pain worse?

_____

Do you have any numbness? ☐ **No** ☐ **Yes**

Please describe: _____

Do you have any weakness? ☐ **No** ☐ **Yes**

Please describe: _____

Review of Systems:

Are you <u>currently</u> experiencing any of the following conditions?

☐ Fever
☐ Chills
☐ Cough
☐ Shortness of breath
☐ Sore throat
☐ Chest pain
☐ Palpitations
☐ Constipation
☐ Diarrhea
☐ Abdominal pain
☐ Headache
☐ Balance problems
☐ Rash
☐ Joint swelling
☐ Incontinence
☐ Feeling "down"

Please list additional aches/pains:

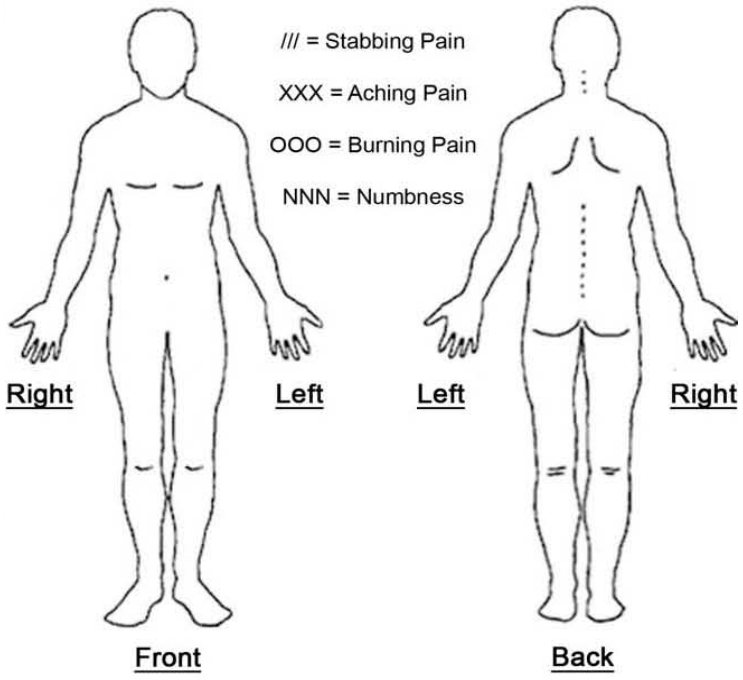
_____

_____

Any new providers in your care? ☐ **No** ☐ **Yes**
Name(s) and phone number(s):

_____

Please draw your pain on the diagrams below. Use the corresponding symbols to show the type and location of pain you feel.



Please rate your pain on a scale of 0 to 10:

0 1 2 3 4 5 6 7 8 9 10

Reviewed with patient by:_____ On date:_____