Follow-Up Intake Form

______________________ / ______________________ / ______________________

Last Name First Name Appointment Date What Dr. are you seeing today?

CC: Chief complaint: What is the reason for this visit?______________________

❑ **NO CHANGES since my last visit.**

If this is a WC injury, what is your injury date? ______________________

Current Work Status: ❑ Regular Duty ❑ Light Duty ❑ Not working due to this injury ❑ Disabled ❑ Retired ❑ Student

LOCATION: What is the location of your INJURY? ***Circle all that apply***

Spine/Back	Neck	Shoulder R L	Arm R L	Elbow R L	Wrist R L	Hand R L
Hip R L	Toes	Finger	Pelvis	Chest	Ribs	Clavicle
Leg R L	Knee R L	Ankle R L	Foot R L	Foot	Other:______________	

Have you had any of these since your last visit? ❑ Injections ❑ Brace/s ❑ Physical Therapy ❑ Surgery ❑ No Surgery

What tests/scans have you had since your last visit? ❑ X-Ray ❑ MRI ❑ CT Scan ❑ Bone Scan ❑ Nerve Test (EMG/NCV)

If you did, where?______________________ **Are you here for test results? Yes No** ______________________

What Kind

What type of pain do you have? ❑ Burning ❑ Diffuse ❑ Dull/Aching ❑ Localized ❑ Radiating ❑ Shooting ❑ Stabbing ❑ Throbbing ❑ Tightness ❑ Tingling

What is your level of pain when active on a scale of 1 - 10? __________

What is your level of pain at rest on a scale of 1 - 10? __________

What is your severity of pain today on a scale of 1 - 10? __________

How long have you had your pain? I 2 3 4 5 6 7 8 9 10 11 12 Hours / Days / Weeks / Months / Years

HELPFUL TREATMENTS: What helpful treatments have you had since your last office visit? ***Check all that apply***

❑ Physical Therapy ❑ Chiropractic Care ❑ Acupuncture ❑ Massage Therapy ❑ Home Exercise ❑ Medication ❑ Bracing

❑ Epidural Steroid Injections ❑ Facet Block Injections ❑ SI Joint Injections

Have you been in any recent accidents since your last visit? ❑ Yes ❑ No If yes, please specify ______________________

Have you ever had a deep vein thrombosis (DVT)? ❑ Yes ❑ No

Have you ever had a pulmonary embolism (PE) ❑ Yes ❑ No

Have there been any NEW Orthopedic or NON Orthopedic conditions/problems since your last visit? ❑ Yes ❑ No

If yes, please list:______________________

MEDICATIONS: Please list current medications and doses. Please mark any medications with an "X" that you need refills on.

______________ / ______________ / ______________ / ______________ / ______________

REVIEW OF SYSTEMS Have you had any problems related to the following systems? ***Circle all that apply***

If "No" circle NONE NONE

Constitutional Systems	Chills	Fever	Headache
Eyes	Blurred	Double Vision	Vision Change
Cardiovascular	Chest Pain	Shortness of Breath	Palpations
Respiratory	Chronic Cough	Wheezes	Asthma
Gastrointestinal	Abdominal Pain	Nausea	Bowel Habit Changes
Genitourinary	Frequent Urination	Urine Retention	Kidney Problems
Musculoskeletal	Neck Pain	Back Pain	Joint Pain
Skin	Rash	Skin Discolor	Persistent Itch
Neurologic	Stroke	Weakness	Vertigo
Psychiatric	Anxiety	Depression	Sleep Disorders