Acct #: ______________

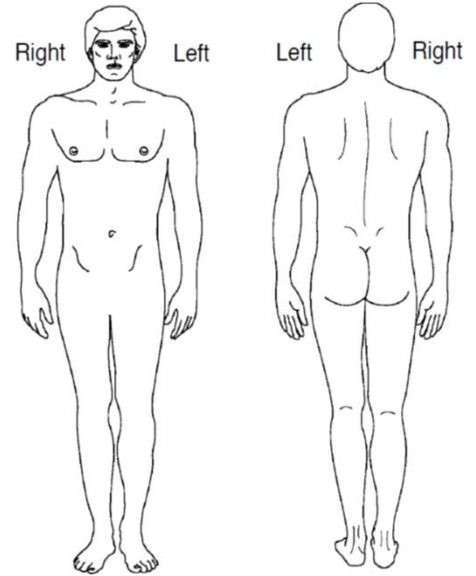
# Follow-up Visit Paperwork

Today's Date: ______________

Name: _________________________________________ Age: ______

DOB: ______________ Primary Care Physician: ______________________________

Email address: ______________________________________




Any other doctor visits since the last visit here?

**Chief complaint**:

**Any changes** in your symptoms?

**Better** with (sit, stand, leaning forward, leaning back, lying down):

**Worse** with (sit, stand, leaning forward, leaning back, walking, morning/evening):

**Pain** (dull, achy, sharp, throbbing, burning):

Location (**mark on body to the right**):

Frequency:

**SINCE THE LAST VISIT….**

**Pain scores for _________________ (name body part)** /10 today; /10 at worst; /10 at best; /10 on average

**Pain scores for _________________ (name body part)** /10 today; /10 at worst; /10 at best; /10 on average

**Medical/Surgical Changes:** Any NEW illnesses, hospitalizations, medications, injuries?

**Family Medical History:** Any NEW diagnoses in your immediate family members?

**Social Changes:** Any NEW changes to your occupation, alcohol use, tobacco use, illegal drug use?

**Allergies/Medications:** Any NEW drug allergies or medications started or stopped?

**Review of Systems:** Any NEW fever, bowel or bladder changes, skin changes (if yes, circle which one)

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**For Staff notes:**

Last clinic visit:

BP:
HR:
Temp:
HT:
WT:

PT: Meds:

Injections:

Blood thinners? Diabetes? Kidney disease?

B/B incontinence/retention? Saddle anesthesia? MRI: