# 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?**__________________________________________

**Location:** What is the location of your injury? ***Check all that apply***

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

**RELATED TREATMENT:**
**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?** ________________________________________________

**QUALITY:**
**What type of pain do you have?** □Burning □Diffuse □Dull/Aching □Localized □Radiating □ Sharp
□Shooting □Stabbing □Throbbing □Tightness □Tingling
**What is your level of pain when active?** *Please Circle* 0 1 2 3 4 5 6 7 8 9 10 most severe

**What is your level of pain at rest?** *Please Circle* 0 1 2 3 4 5 6 7 8 9 10 most severe

**What is your severity of pain today?** *Please Circle* 0 1 2 3 4 5 6 7 8 9 10 most severe

**DURATION:**
**How long have you had your pain?** 1 2 3 4 5 6 7 8 9 10 11 12 Hours / Days / Weeks / Months / Years
**FOLLOW –UP QUESTIONS:**
**Have you had any of these since your last visit?** □ Injections □ Brace/s □ Physical Therapy □ Surgery □ No Surgery

**HELPFUL TREATMENTS:** Have you had any of these treatments since your last 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

**NON HELPFUL TREATMENTS:** Have you had any of these treatments since your last 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

**Current Work Status:** Please answer this question, if you are a Workers Compensation patient.
□ Regular Duty □ Light Duty □ Not working due to this injury □ Disabled □Retired □Student

**Smoking Status:** □ Never Smoked □ Former Smoker □ Current every day Smoker □ Current someday Smoker
If you smoke, how many packs a day? ___________________

**Have you been in any recent accidents since your last visit?** □**Yes** □ **No If yes, please specify** ______________________________
**Have there been any NEW Orthopedic conditions/problems since your last visit?** □ Yes □ No
If yes, please list: ________________________________________________________________________

**Have there been any NEW "NON Orthopedic" conditions/problems since your last visit?** □ Yes □ No
If yes, please list: ________________________________________________________________________

**If you are here today to receive test results, please check off which ones:** □ MRI □ CT □BONE SCAN □ EMG

**Vitals**: **What is your height and weight? Height: __________** Ft **___________** Inches **Weight: __________** lbs **________** oz

**MEDICATIONS: Please list current medications and doses. Please mark any medications with an "X" that you need refills on.**
_________________/___________________/_____________________/____________________/______________________

_________________/___________________/_____________________/____________________/______________________

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