Follow Up Patient Information Form

Name: _____ Date of Birth: ____/____/_____ Today's Date: ____/____/_____

Circle the Location of your Chief Problem(s) and Symptoms?

Neck Pain	Right	Left	Both	Shoulder Pain	Right	Left	Both	Hip Pain	Right	Left	Both
Low Back Pain	Right	Left	Both	Elbow Pain	Right	Left	Both	Knee Pain	Right	Left	Both
Mid-Back Pain	Right	Left	Both	Wrist Pain	Right	Left	Both	Ankle Pain	Right	Left	Both
Headaches	Right	Left	Both	Hand Pain	Right	Left	Both	Foot Pain	Right	Left	Both

When did Symptoms Start?			**If you had an Injury, Describe:**	
Did you have an INJURY?	No	Yes		

How Severe is the Pain on a Scale of 0-10 (0-NO PAIN, 10-WORST PAIN IMAGINABLE)?			Now: ____/10	Worst Pain: ____/10
How Often are Symptoms Present?	Constantly	Frequently	Intermittently	Rarely
Have Symptoms Changed Since Last Visit?	Getting Worse	Getting Better	Staying the Same	

Describe Symptoms	Deep	Dull	Achy	Throbbing	Stiffness	Cramping	Pressure	Electrical
	Sharp	Stabbing	Numbness	Tingling	Burning	Popping	Clicking	Spasms

What makes the Symptoms WORSE?	
What makes the Symptoms BETTER?	

Does the Pain Radiate?	Down the Right Arm	Down the Left Arm	Down the Right Leg	Down the Left Leg

Any Numbness?	No	Yes	**If yes, Where?**	
Any Weakness?	No	Yes	**If yes, Where?**	

Are you Currently Doing Any of the Following Treatments?	**Physical Therapy**	Yes	No	**If Yes, Is it Helping?**	Yes	No
	Chiropractor	Yes	No	**If Yes, Is it Helping?**	Yes	No
	Massage Therapy	Yes	No	**If Yes, Is it Helping?**	Yes	No
	Injections	Yes	No	**If Yes, Is it Helping?**	Yes	No
	Anti-Inflammatories	Yes	No	**If Yes, Is it Helping?**	Yes	No
	Pain Medications	Yes	No	**If Yes, Is it Helping?**	Yes	No

Do You Have Any New Medical Problems Since Last Visit:	
Have You Had Any New Surgeries Since You Last Visit:	

List All Medications, including Dose, You Take (IMPORTANT)	
Allergies to Meds	

Do You Take any Blood Thinners (CIRCLE)?	Coumadin/Warfarin	Plavix	Pradaxa	Brilinta	Aleve/Naproxen
	Aspirin	Eliquis	Xarelto	Ibuprofen/Advil	Other

Circle Anything that Applies to You. ALL CONFIDENTIAL!	No Tobacco	Smoke Cigarettes	Smoke Cigars	Chew Tobacco	Vape
	No Alcohol	**If you Drink Alcohol, How Much?**	_____ Drinks Per Day / Week / Month / Year		
	No Drugs Ever	Smoke Marijuana	Edible Marijuana	CBD Oil	Other Drugs

Does Pain affect your Ability to Work?	No	Yes	**Describe:**	

Height: _____	Weight: _____	BP: _____/_____	Pulse: ____	O_2 Sat: _____%