



Patient Follow-up Form

Patient Name: _____ DOB: _____ Age: _____

BP: _____ \ _____ HR: _____ Weight: _____ lbs Height: _____ft _____in Handedness: Right Left

Tests since last visit: _____

Treatments since last visit: _____

Concerns you would like addressed this visit: _____

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

Ache
^ ^ ^ ^ ^
^ ^ ^ ^ ^
^ ^ ^ ^ ^

Numbness
O O O O
O O O O
O O O O

Pins & Needles
= = = =
= = = =
= = = =

Burning
X X X X
X X X X
X X X X

Stabbing
/ / / /
/ / / /
/ / / /

Medications: (circle those that need to be refilled)

Pharmacy:

Address: _____

Phone Number: _____

Allergies: _____

Any changes to your medical history that we should be made aware of? (surgeries, stents, newly diagnosed conditions, etc?) Yes No

If yes, please list: _____

How bad is your pain? Circle the number on each of the lines below to indicate your pain.

How bad is your **neck** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **arm** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **middle back** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **low back** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **leg** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

Please identify which ONE of the following best describes the amount of spine (back or neck) vs extremity (leg or arm) pain you feel:

- 100% Spine pain to 0% Extremity pain
- 90% Spine pain to 10% Extremity pain
- 80% Spine pain to 20% Extremity pain
- 70% Spine pain to 30% Extremity pain
- 60% Spine pain to 40% Extremity pain
- 50% Spine pain to 50% Extremity pain
- 40% Spine pain to 60% Extremity pain
- 30% Spine pain to 70% Extremity pain
- 20% Spine pain to 80% Extremity pain
- 10% Spine pain to 90% Extremity pain
- 0% Spine pain to 100% Extremity pain