LABEL, or:
Name: ______________________
DOB: _________ Date: _________

# FOLLOW-UP EVALUATION FORM

| VISIT INFORMATION | Age: Height: Weight: Handedness: ☐ Right ☐ Left |
|---|---|
| Primary Care Provider: | Referring Provider: |
| What is the main reason for seeking medical attention today? | |
| When did this start? | |
| How did this start? ☐ Work-related ☐ Trauma ☐ Fall ☐ MVA ☐ Unknown ☐ Other | Further Details: |

**HISTORY** *please check all that apply*

Describe your pain:

| | | |
|---|---|---|
| ☐ Achy | ☐ Burning | ☐ Cramping |
| ☐ Dull | ☐ Numb | ☐ Pressure |
| ☐ Radiates | ☐ Sharp | ☐ Sore |
| ☐ Squeezing | ☐ Stabbing | ☐ Tightening |
| ☐ Throbbing | ☐ Other: | |

**Is your pain?** ☐ Constant or ☐ Intermittent

**Is your pain?** ☐ Improving or ☐ Worsening or ☐ Stable

**What makes the pain worse?**
☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Moving
☐ Other

**What makes the pain better?**
☐ Sitting ☐ Standing ☐ Walking ☐ Lying ☐ Moving
☐ Other

**Please draw the location of your pain/discomfort:**

Mark “P” for pain and “N” for numbness

| What treatments have you tried for this problem? | Helpful | Not Helpful |
|---|---|---|
| Acupuncture | | |
| Chiropractic | | |
| Massage | | |
| TENS | | |
| Physical Therapy | | |
| Psychology | | |
| Braces | | |
| Injections | | |
| Surgery | | |
| Other: | | |

**Do you take any pain medications?** ☐ **Yes** ☐ **No**

If yes, please list:

What medications have you previously tried for this problem?

**What tests have you had for this problem?**

☐ X-Rays ☐ CT Scan
☐ MRI ☐ EMG (nerve study)
☐ Other:

**How bad is the pain?** *Please use the scales below*

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

No pain — Moderate pain — Worst pain

0 1 2 3 4 5 6 7 8 9 10

**Are you experiencing any of the following?**
*Please check if present*

| | | | |
|---|---|---|---|
| Fever or Chills | | Headaches | |
| Unexplained weight loss | | Weakness | |
| Blurred vision | | Numbness or tingling | |
| Difficult swallowing | | Joint Swelling | |
| Shortness or breath | | Arthritis | |
| Chest Pain | | Depression | |
| Heart Palpitations | | Anxiety | |
| Nausea or vomiting | | Sleep Problems | |
| Black Stools | | Dizziness | |
| Loss of bowel control | | Easy Bleeding or blood thinners | |
| Loss of bladder control | | Other: | |
| Skin Rash | | | |