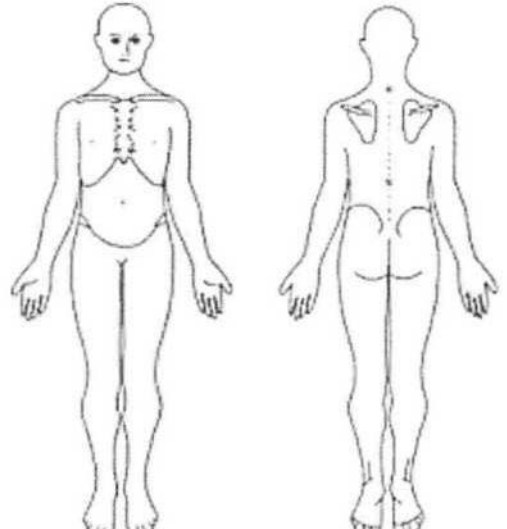
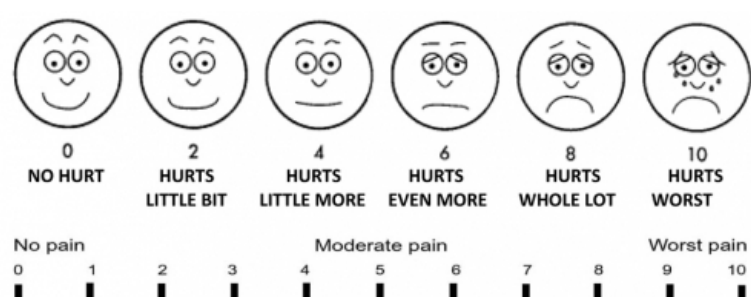


LABEL, or:
Name: _____
DOB: _____ Date: _____

FOLLOW-UP EVALUATION FORM

VISIT INFORMATION	Age: _____ Height: _____ Weight: _____ Handedness: <input type="checkbox"/> Right <input type="checkbox"/> Left
Primary Care Provider: _____	Referring Provider: _____
What is the main reason for seeking medical attention today?	
When did this start?	
How did this start? <input type="checkbox"/> Work-related <input type="checkbox"/> Trauma <input type="checkbox"/> Fall <input type="checkbox"/> MVA <input type="checkbox"/> Unknown <input type="checkbox"/> Other Further Details: _____	
HISTORY <i>please check all that apply</i>	
Describe your pain:	
<input type="checkbox"/> Achy	<input type="checkbox"/> Burning
<input type="checkbox"/> Dull	<input type="checkbox"/> Numb
<input type="checkbox"/> Radiates	<input type="checkbox"/> Sharp
<input type="checkbox"/> Squeezing	<input type="checkbox"/> Stabbing
<input type="checkbox"/> Throbbing	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cramping	<input type="checkbox"/> Pressure
<input type="checkbox"/> Sore	<input type="checkbox"/> Tightening
Please draw the location of your pain/discomfort:	
Mark "P" for pain and "N" for numbness	
	
Is your pain? <input type="checkbox"/> Constant or <input type="checkbox"/> Intermittent Is your pain? <input type="checkbox"/> Improving or <input type="checkbox"/> Worsening or <input type="checkbox"/> Stable What makes the pain worse? <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Moving <input type="checkbox"/> Other _____ What makes the pain better? <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying <input type="checkbox"/> Moving <input type="checkbox"/> Other _____	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list: _____	
What medications have you previously tried for this problem?	
What tests have you had for this problem?	
<input type="checkbox"/> X-Rays	<input type="checkbox"/> CT Scan
<input type="checkbox"/> MRI	<input type="checkbox"/> EMG (nerve study)
<input type="checkbox"/> Other: _____	
How bad is the pain? <i>Please use the scales below</i>	
	
Are you experiencing any of the following? <i>Please check if present</i>	
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	