



FOLLOW-UP

Name: _____

Date: _____

Doctor: _____

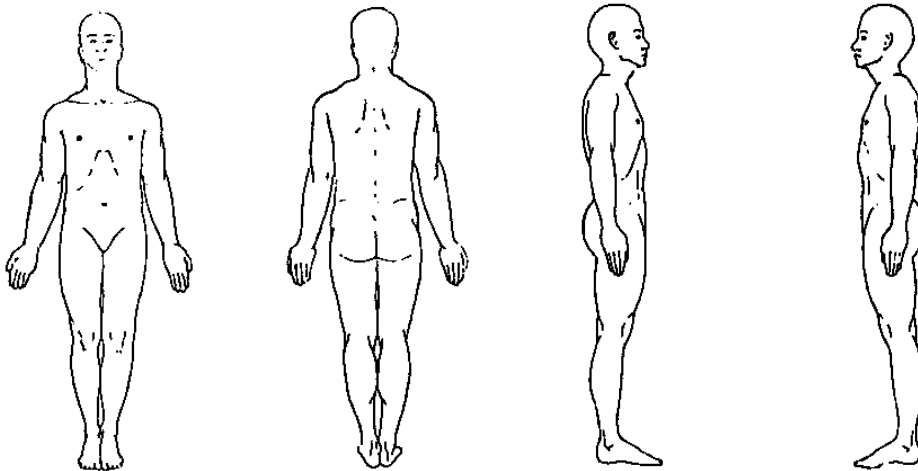
WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY?

- Scheduled, Routine Follow Up
- New Problem, New Illness or New Injury
- Urgent Medication Issue

1. HOW WOULD YOU DESCRIBE YOUR SYMPTOMS?

- | | | |
|--|--|--------------|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Spasms | Other: _____ |
| <input type="checkbox"/> Bone Pain | <input type="checkbox"/> Nausea / Vomiting | _____ |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck Pain | _____ |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Numbness | _____ |
| <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Weakness | _____ |
| <input type="checkbox"/> Limb Pain | <input type="checkbox"/> Weight Loss | _____ |

2. LOCATION OF PAIN: (SHADE IN THE PAINFUL AREAS ON THE DIAGRAM BELOW)



3. HAS YOUR PAIN HAD A SIGNIFICANT NEGATIVE IMPACT ON YOUR FUNCTIONING?

NO OR YES (If yes, please complete below)

	Increased Functioning	Decreased Functioning	No Change in Functioning
General Activity			
Mood			
Walking			
Normal Work (includes work outside the home & housework)			
Relations with Other People			
Enjoyment of Life			
Sexual Activity			
Sleep			

