PATIENT FOLLOW-UP

In order for us to best serve you please provide us with the following information.

PLEASE PRINT

Name: ____ Date: _________________
Address: _______________________________City:_________ State: ____ Zip:_________
Phone#: (Home)____________________________ (Work)___________________________

1. **Describe your current symptoms**
   ____
   ____
2. **How often do you experience your symptoms?**
   (1) Constantly (76-100% of the day) **(3)** Occasionally (25-50% of the day)
   (2) Frequently (51-75% of the day) **(4)** Intermittently (0-25% of the day)
3. **What describes the nature of your symptoms?**
   (1) Sharp **(3)** Numb **(5)** Burning
   (2) Dull ache **(4)** Shooting **(6)** Tingling
4. **How are your symptoms changing?**
   (1) Getting better
   (2) Not changing
   (3) Getting worse
5. **Since beginning of care, has anything aggravated the condition? __Yes__No**
   Describe: ____
6. **Numeric Pain Rating Scale:**
   (No Pain) ( )0 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7 ( )8 ( )9 ( )10 (unbearable pain)
7. **Restrictions of activities of Daily Living:**
   (No limitations) ( )0 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7 ( )8 ( )9 ( )10 (totally disabled)
8. **Do you have any new symptoms? ___Yes ___No**
   Describe: ____
9. **Are you satisfied with the treatment received to date?**
   ___Very pleased _____ Somewhat pleased _____Unsatisfied

We welcome any additional comments you would like to make:

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