Specialists In Rehabilitation Medicine, PC

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Please fill out this brief questionnaire to assist us with your follow up visit.

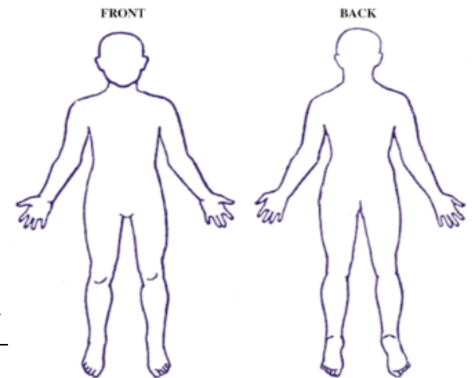
Name: ______________________ **Date:** ______________

Reason for visit (Chief Complaint): ______________________

If you are having **pain**, circle one number in each row that represents your pain level.

0 is no pain & 10 is the worst pain imaginable.	☺					😐					☹
Typically, my pain is about a…	0	1	2	3	4	5	6	7	8	9	10
At best, my pain is about a…	0	1	2	3	4	5	6	7	8	9	10
At worst, my pain is about a…	0	1	2	3	4	5	6	7	8	9	10
This past week, how many bad days did you have? _______											

Please mark your areas of discomfort, numbness and/or tingling.



☐ **NO PAIN, numbness or tingling**

Have you had any improvement? _______% ☐ The Same ☐ Worse
Is your pain/condition: ☐ Constant ☐ Intermittent ☐ Positional ☐ Other
What does your pain feel like (gnawing, achy, sharp, stabbing, etc.)? ______________
What makes your condition worse? ______________
What makes your condition better? ______________
What day to day activities are you struggling with? ______________

Interval Past Medical history/ surgeries/ medications/ allergies/ family history.

Have any of your medical conditions changed? ☐ Yes ☐ No
Any changes to pertinent Family History? ☐ Yes ☐ No
Have you seen any other physicians? ☐ Yes ☐ No
Have you had any changes in medication allergies? ☐ Yes ☐ No
Do you continue to work? ☐ Yes ☐ Yes, with restrictions ☐ No ☐ Retired
Are you exercising/ stretching? ☐ Yes ☐ No
Any changes to alcohol/smoking/drug habits? ☐ Yes ☐ No
Are you sleeping well? ☐ Yes ☐ No
Have you gained/ lost weight? ☐ No Change ☐ Gained ☐ Lost
Do you have any numbness and tingling? ☐ Yes ☐ No
Have you had any night sweats? ☐ Yes ☐ No
Do you have any fevers or chills? ☐ Yes ☐ No
Have you fallen since your last visit? ☐ Yes ☐ No If Yes, How many falls? _________
If Yes, did an injury occur? ☐Yes ☐No

Have you had any of the following since your last visit: ☐ Blood tests ☐MRI ☐ CT ☐ X-rays ☐ Bone Scan
If yes, where were tests performed?: ______________

Patient Signature: ______________________ Date: ______________

Physician Signature: ______________________ Date: ______________

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