Follow-Up Medical History Intake Form

Name:_____ Date of Birth: _____ Date: _____

What problem/issue brings you here today? _____

Is this visit a follow-up after a procedure/injection? ☐ Yes ☐ No

Since your last visit, are your symptoms: ☐ Better ☐ Worse ☐ The Same

If better, by how much on a scale of 0-100% (if 0 was the way you were and 100% was completely normal) _____ %

Is your pain? ☐ Aching ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Dull ☐ Burning ☐ Numbness☐ Tingling ☐ Other (Describe): _____ **Is this a change since your last visit?** ☐ Yes ☐ No

Is your pain? ☐ Constant ☐Intermittent **Is this a change since your last visit?** ☐ Yes ☐ No

What makes it worse? ☐ Walking ☐ Sitting ☐ Standing ☐ Exercise ☐ Lying down ☐ Other (Describe) _____ **What makes the pain better?** _____

Please make a *mark on the line* below to indicate the level of discomfort you have today.

No Pain _____ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Since your last visit, have you? ☐ Started Physical Therapy ☐ Seen Chiropractor ☐ Seen a Surgeon

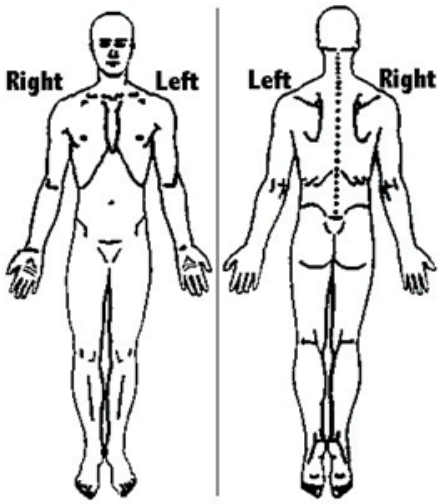
Since your last visit have you started any new medications or stopped taking any of your medications? ☐ Yes ☐ No
Please list: _____

Any new medical problems or surgeries since your last visit? ☐ Yes ☐ No Please list:_____

Any new allergies to medications? ☐ Yes ☐ No
If yes, list: _____

If you smoke cigarettes/use tobacco have you? ☐ No change ☐ decreased use ☐ increased use ☐ Quit ☐ Trying to quit

Please Draw Where You Have Pain



Check any of the following symptoms that you have experienced since your last visit?

Constitutional ☐ Fevers ☐ Weight gain ☐ Weight Loss ☐ Fatigue
Cardiac ☐ Chest pain/pressure ☐ heart palpitations ☐ Low blood pressure ☐ high blood pressure ☐ shortness of breath
Respiratory ☐ Persistent cough ☐ coughing up blood ☐ Wheezing
Gastrointestinal ☐Diarrhea ☐ Constipation ☐ Blood in stool ☐ nausea/vomiting ☐ Heartburn/indigestion
Musculoskeletal ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐Cramps
Neurologic ☐ Headaches ☐ Fainting ☐ Dizziness ☐ Seizures ☐ New weakness ☐ New numbness/tingling
Skin ☐Rash ☐ Nail or hair changes ☐ Hives ☐ Sores that don't heal
Endocrine ☐ Excessive thirst ☐ Cold intolerance ☐ heat intolerance
Genitourinary ☐ Blood in urine ☐Urgency to urinate ☐Painful urination ☐ Frequent urination ☐ Difficulty urinating ☐loss of control of bladder ☐ loss of control of bowels
Hematology ☐ Easy or frequent bruising ☐ Prolonged bleeding
Psychiatric ☐ Depression or depressed mood ☐ Anxiety ☐ difficulty sleeping

Have you had any falls since your last visit? ☐ Yes ☐ No
How many? ☐ 1 ☐ 2 or more ☐ with injury ☐no injury