Follow-Up Medical History Intake Form

Name:_____Age:_____Today's Date:_____/_____/_____

What problem brings you here today?_____

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

If better, how much have they improved (on a scale of 1 – 100%) _____

What would you like to accomplish with today's visit? _____

Please list activities that you are able to do now that you weren't able to do before_____

_____

Describe your current exercise activities _____

Time per exercise session:_____ How many days per week do you exercise?_____

Please check any symptom you are experiencing:

☐ Low Back Pain	☐ Dizziness	☐ Fever	☐ Wheezing
☐ Joint Pain	☐ Headaches	☐ Weight Loss	☐ Coughing
☐ Joint Swelling	☐ Urinary Frequency	☐ Night Sweats	☐ New Rash
☐ Muscle Pain	☐ Loss of Control of Urine	☐ Vision Change	☐ Psoriasis
☐ Night Pain	☐ Loss of Control of Bowels	☐ Double Vision	☐ Skin Breakdown
☐ Numbness	☐ Constipation	☐ Difficulty Swallowing	☐ Depressed Mood
☐ Tingling	☐ Nausea	☐ Chest Pain	☐ Sleep Problems
☐ Weakness	☐ Vomiting	☐ Palpitations	☐ Anxiety
☐ Falls	☐ Black Stools	☐ Shortness of Breath	

Pain Severity: Please rate your pain since your *last visit* according to the scale.

Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Least Pain	0	1	2	3	4	5	6	7	8	9	10
Average Pain	0	1	2	3	4	5	6	7	8	9	10

Overall Severity: ☐ Mild Nuisance ☐ Mild to Moderate (can live with it)
☐ Moderate (having difficulty managing pain) ☐ Severe (ruining life)

What does the pain feel like? (Please check all that apply): ☐ Sharp ☐ Stabbing ☐ Aching ☐ Dull ☐ Burning
☐ Pins and Needles ☐ Cramping ☐ Throbbing ☐ Other _____

Associated Symptoms: ☐ Numbness ☐ Weakness ☐ Other Date pain started: _____

Average number of days in pain per week: _____ Is your pain: ☐ Constant OR ☐ Comes and Goes

Duration of pain each day: ☐ 1 hour or less ☐ 1-4 hrs ☐ 4-8 hrs ☐ Always while awake ☐ 24 hrs/day

Time of day pain is worst: ☐ First awake ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime

Time of day pain is least: ☐ First awake ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime

Activities that relieve pain: ☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Bending Forward ☐ Bending Back
☐ Lifting ☐ Looking Up ☐ Looking Down ☐ Straining ☐ Other:_____

Activities that increase pain: ☐ Lying Down ☐ Sitting ☐ Standing ☐ Walking ☐ Bending Forward ☐ Bending Back
☐ Lifting ☐ Looking Up ☐ Looking Down ☐ Straining ☐ Other:_____

Pain compared to when it 1st started: ☐ Much Improved ☐ Somewhat Improved ☐ No Change ☐ A Little Worse ☐ Much Worse

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Light Duty ☐ Off-Duty/Injured ☐ Not Working ☐ Retired

Any new medical problems, surgeries, or drug allergies since your last visit? _____

Alcohol Use: _____ alcoholic beverages per week Tobacco Use: _____ cigarettes/cigars/smokeless tobacco per day