ROOM #:________

Date Seen: ______________________ **Blood Pressure:**______________________ **Pulse:** __________

Patient's Last Visit:______________________ **Weight:** __________ **Height:**__________ **O_2 Sats:** __________

For office use only above this line.

Patient Name:______________________ **Date of Birth:** ______________________ **Age:** __________

Referring Physician:______________________ **Insurance Carrier:**______________________

On a scale of 0-100%, how much improvement have you experienced since your surgery? If no better, put 0%: __________

On a scale of 0-10 (0 being no pain and 10 being the worst pain), what is your pain right now? __________

New Imaging since your last visit .. ☐ **MRI** ☐ **CT** ☐ **X-Rays** ☐ **N/A** ☐ **Other:** __________

Imaging of .... ☐ **Brain** ☐ **Cervical Spine** ☐ **Thoracic Spine** ☐ **Lumbar Spine** ☐ **Other:** __________

Where were these images done? ... ☐ **Health Images** ☐ **Invision** ☐ **Resiliance** ☐ **Touchstone** ☐ **Other:** __________

When were these images done? ______________________

New diagnostic since your last visit: ☐ **EMG** ☐ **Discogram** ☐ **Injection**

Done by Dr:______________________ **Date:**__________

List any new symptoms since your last visit:

____

____

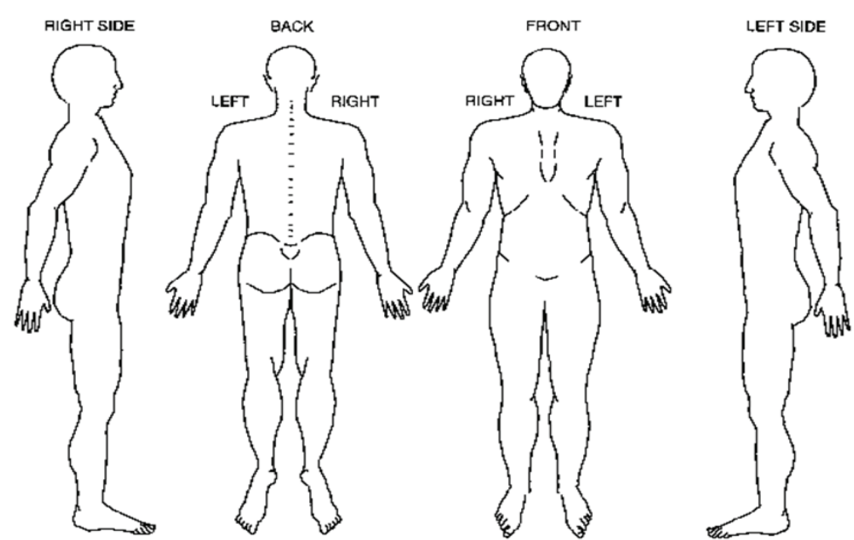
What are your current symptoms?

____

____

Mark the area on the diagram where you feel your pain. Use the appropriate symbol below to describe your type of pain.

Ache = A
Burning = B
Numbness = N
Pins & Needles = P
Stabbing = S
Throbbing = T



PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY USING (PLEASE PRINT NEATLY) If none, please place ✓ in box: ☐

Name and dose (i.e., 2 mg, 60 mg, etc)	How often (i.e., one tab daily, one tab twice daily, two at bedtime)
SEE ATTACHED SHEET	

Patient Name:____

REVIEW OF SYSTEMS: Please ✓ in box next to any symptom in which you are currently experiencing:

General			
☐ Recent weight loss: # lbs ______	☐ Ringing in ears	☐ Nausea	☐ Rashes
☐ Recent weight gain: # lbs ______	☐ Chest pain	☐ Frequent indigestion	☐ Recent change in wart / mole
☐ Fever	☐ Palpitations	☐ Black, tarry or bloody stools	☐ Easy bleeding or bruising
☐ Night sweats	☐ Shortness of breath	☐ Difficulty urinating	☐ Depression
☐ Fatigue	☐ Swelling of feet or ankles	☐ Incontinence	☐ Anxiety
☐ Blurred vision	☐ Fainting	☐ Burning with urination	☐ Difficulty falling asleep
☐ Double vision	☐ Frequent cough	☐ Excessive thirst	☐ Early morning awakenings
☐ Blindness	☐ Difficulty breathing	☐ Unusual appetite	☐ Persistent feeling sad or blue
☐ Hearing loss	☐ Coughing up blood	☐ Frequent urination	☐ Loss of ability to enjoy life

Musculoskeletal		
☐ Back pain	☐ Joint swelling	☐ Shooting left arm pain
☐ Joint pain	☐ Leg cramps	☐ Shooting right leg pain
☐ Joint stiffness	☐ Shooting right arm pain	☐ Shooting left leg pain

Neurological		
☐ Fatigue	☐ Gait abnormality	☐ Seizure
☐ Weight loss	☐ Headache	☐ Tingling
☐ Balance difficulty	☐ Loss of sensation in a specific body area: ______________	☐ Tremors
☐ Dizziness	☐ Loss of strength in a specific body area: ______________	☐ Trouble with balance
☐ Fainting spells	☐ Numbness	☐ Trouble with coordination
☐ Falls	☐ Memory problems	

This Information is true and complete to the best of my knowledge:

_______________________________________ _______________________

Signature of Patient or Legal Guardian *Date*