PATIENT FOLLOW-UP EXAM
(patient to complete)

Date:_____ **Patient Name:**_____**DOB** ___/___/_____

Pharmacy Name (and town)_____

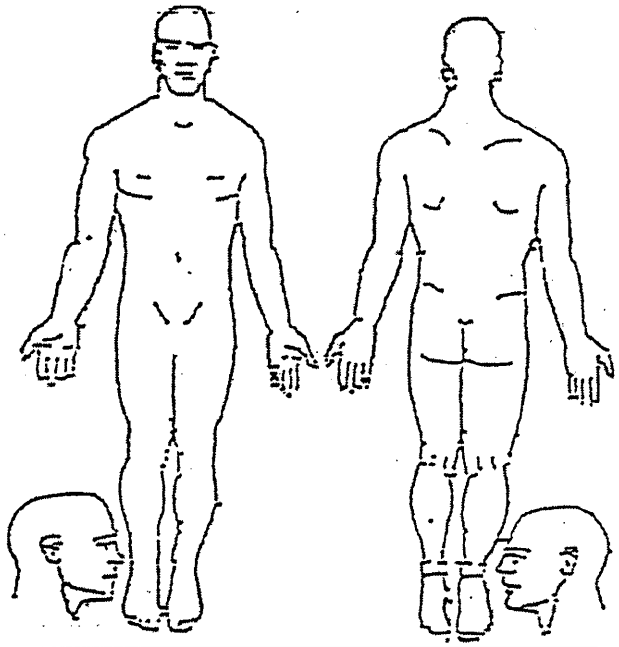
Has your insurance/address/phone number changed since your last visit? Yes / NO
Is your pain from an Auto or Worker's Comp Accident? YES / NO
Did you have a recent MRI/CT Scan or diagnostic test? YES / NO
If yes please give all reports and CD/Films to the receptionist

Chief Complaint:_____

Pain Level (0-10): 0 1 2 3 4 5 6 7 8 9 10
How often is your pain present?
( ) Occasional ( ) Frequent ( ) Constant

Have you had any changes in Medication, Allergies or Medical condition? _____YES _____No
(if Yes, please explain in additional comments)

If you recently had a procedure:
Indicate how much your pain has improved (decreased)
None 10% 25% 50% 75% 100%



Please shade area where your pain is located on the diagram above.

Additional Comments:_____

My signature below acknowledges that I was present at this office
And that **I have received the practice's HIPPA notice of privac**
X_____
Patient's Signature

_____

(Doctor to fill out)

Comments:_____

Chief Complaint:_____

_____

_____

Dx:_____

Plan:_____

_____

X_____ _____/____/_____
Doctor's Signature Date