

Action Physical Medicine and Rehabilitation

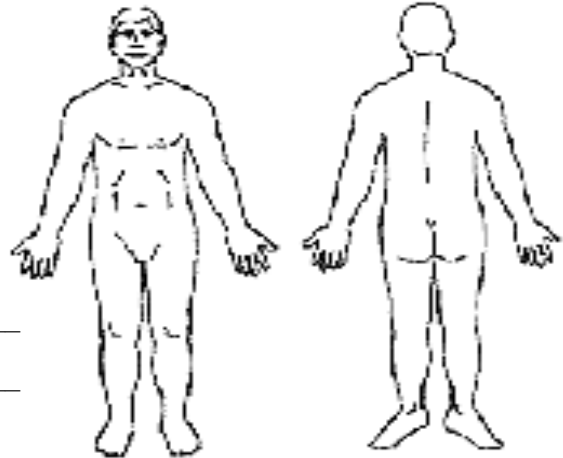
Follow up Appointment

Patient Name: _____

Reason for Visit:

Onset of Chief Complaint: _____

Pain Medication/Dosage/Time last taken



Shade or "X" body area

Changes to Medication:

Severity of Pain: **Today**

0 1 2 3 4 5 6 7 8 9 10

_____ Quality of Pain: Stabbing, Burning, Dull, Sharp,
 _____ Tingling, Numbness, Aching, Other: ____

Increased by:

_____ Movement / Activity Sitting / Standing
 _____ Bending / Exercise Coughing / Sneezing
 _____ Nothing

Exacerbating Factors / Pain

Current Smoker: Yes/ No / Packs per day: _____

Former Smoker: Yes/No /Date quit: _____

Number of drinks per week: _____

Nothing

Pain Relieving Factors:

Medication: ____

Heat / Ice Therapy / Rest /

Review of Systems: (circle all that apply, must be filled out at **EACH VISIT** for insurance purposes)

General: Weight increase / Weight decrease / Appetite change / Difficulty sleeping / Fatigue

Skin: Rash / Paleness / Redness / Breakdown / Color change / Temperature change / Easily bruise

Musculoskeletal: Joint pain / Muscle pain / Tenderness / Stiffness / Weakness / Swelling

Cardiovascular/Respiratory: Chest pain / Palpitations / Shortness of breath / Cough / Wheezing

Neurological: Tingling / Burning / Numbness / Headache / Falls / Poor balance

Psychological: Anxiety / Depression / Irritability / Mood swings

Gastrointestinal: Bowel incontinence / Diarrhea / Constipation / Bladder incontinence

Eyes: Blurred vision / Double vision / Glasses

Other Systems: Hearing difficulty / Problems with nose or throat / Sexual dysfunction / Excessive bleeding

Please list any other concerns you would like to discuss today:

All the above information is true, accurate and complete to the best of my knowledge.

Patient Name: _____ Signature: _____ Date: ____/____/____

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Follow up Appointment

Office Use Only ↓ **Vitals:** Ht: ____ Wt: ____ T: ____ B/P: ____ P: ____ R: ____
