COLUMBIA | REHABILITATION AND REGENERATIVE MEDICINE

FOLLOW UP FORM

Patient Name: ______________________ **Today's Date**____/____/____
Date of Birth: ____/____/____

What problem/issue brings you in today?

Is it a pain issue? (Circle one): YES / NO PAIN

Is this new from last visit? YES/NO
If yes, when and how did it start?

Please describe what the pain feels like: Achy, Burning, Cramping, Stabbing, Stiff, Tingling, Numbness, Dull, Tight, Pulling **(Skip if no pain)**

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

What makes it *worse*?	sitting	standing	lying	walking	exercise	nothing	Other:
What makes it *better*?	sitting	standing	lying	walking	exercise	nothing	Other:

What do you want to accomplish from today's visit? (circle all that apply) Diagnosis, Treatment Options, Imaging (XR/MRI), Injection/Procedure, Medications

If you had a procedure at your last visit, was it helpful? YES/NO If procedure done for pain, what % relief did you experience? __________%

If you were recommended physical, occupational or speech and language therapy at last visit, did you start? YES/NO
If yes, how many sessions have you completed? ___________

If you were recommended medication(s) at last visit, were they helpful? YES/NO

NEW Medical and Surgical History:

NEW Allergies to Medications:

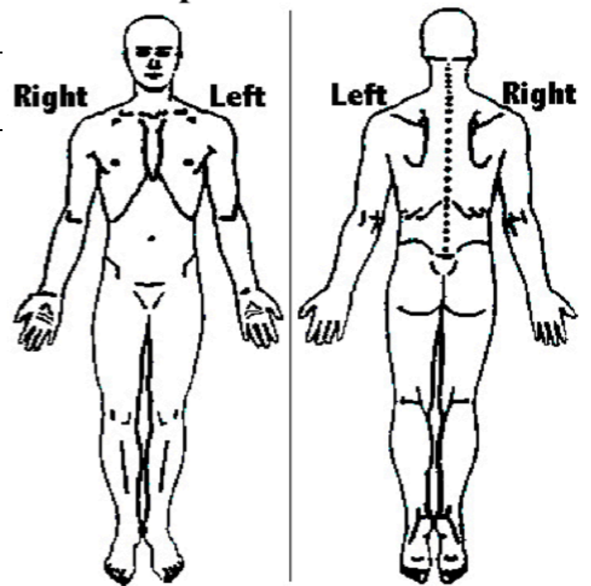
Changes in Medications:

Social History

- Exercise:
- Tobacco Use Current/Quit/Never
- #Alcoholic Beverages/week
- Occupation:

Review of systems:

- Weakness/numbness Y/N
- Bowel/bladder dysfunction Y/N
- Current musculoskeletal pain Y/N
- Other notable symptoms: ______________________________



Patient's signature: ____________________________________

Physicians 'initials/Date: ____________________________