Follow Up Intake Questionnaire -- Hayes

Patient Account #_____
Doctor # _____
Reviewed By _____

Name_____DOB:_____Age:____Date: _____
Last First M.I.

1. **What is the reason for the visit today?**
   - ☐ Review ordered tests
   - ☐ Evaluate progress of therapy/injection
   - ☐ Discuss continuing problem
   - ☐ Discuss new problem: _____
   - ☐ Accident (auto or slip/fall)

2. **Please circle on the line below how bad your pain is NOW.**

Back Pain	**0 --—1--------2--------3--------4--------5--------6--------7-------8-------9----------10 Worst**
Leg Pain	**0 --—1--------2--------3--------4--------5--------6--------7-------8-------9----------10 Worst**
Neck Pain	**0 --—1--------2--------3--------4--------5--------6--------7-------8-------9----------10 Worst**
Arm Pain	**0---—1--------2--------3--------4--------5--------6--------7-------8-------9----------10 Worst**

3. **Current problem is <u>unchanged</u> OR <u>changed</u> (circle one) from last visit on_____(date). Describe changes:**

_____

_____

4. **What medication(s) and how much of over the counter or prescription medication are you currently taking**? _____

_____

5. **How many sessions of therapy have you had since the last office visit?** _____ ☐ N/A
6. **How many injection days have you had since the last office visit?** _____ ☐ N/A
7. **Medical history (circle):** ☐ Not changed ☐ Changed on_____Date ___
   Describe below:

_____

_____

_____

8. **Are you currently working?** ☐ Yes ☐ No

Height:_____Ft._____inch. **Weight_____lbs**

Patient Signature_____ **Date** _____