Patient Account #_____
Doctor # _____
Reviewed By _____

Follow Up Intake Questionnaire for Dr. Lee

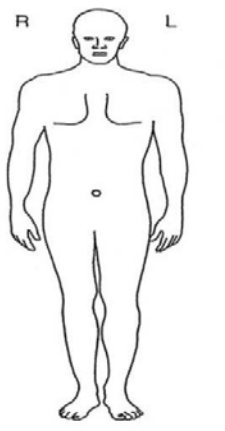
Name_____DOB:_____Age:_____Date:_____
Last First M.I.

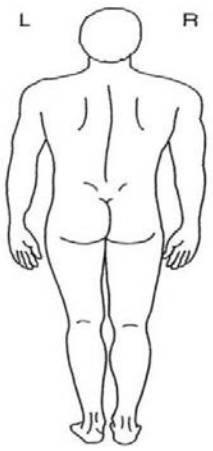
Height:_____Ft._____inch. **Weight_____lbs**

1. My main area of pain is: _____
2. What makes it better? _____
3. What makes it worse? _____
4. Comments or goals for today's visit: _____
5. Any hospitalizations, new diagnosis or health changes since your last visit?
   _____
6. Are you more active since your last visit? Please explain: _____
7. Have you reduced your use of pain medications? _____
8. What are your goals with your treatment?
   a. _____
   b. _____
   c. _____
9. List the **DATES & TIMES** of **ALL PAIN** medications taken to treat your **PAIN** in the past 48 HRS.

Medication Name	Date taken	Time of day medication taken
	/ /	: AM/PM
	/ /	: AM/PM
	/ /	: AM/PM
	/ /	: AM/PM
	/ /	: AM/PM
	/ /	: AM/PM

10. Using the picture below, shade the areas of pain to be addressed today.





Patient Signature: _____ **Date:** _____

Follow Up Intake Questionnaire, p. 2

Patient Account #_____
Doctor # _____
Reviewed By _____

Name_____
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. **Is current problem <u>unchanged</u> OR <u>changed</u> (circle one) from last visit**?
   Describe changes:

   _____

   _____

4. **What other 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