PLEASE FILL OUT THE FOLLOWING INFORMATION COMPLETELY

The Physiatry Medical Group

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Name: _____MR#_____(for office use) DOB:_____ Age:_____ Date: _____
Email Address:_____ Pharmacy(if different then last visit):_____

PLEASE CHECK YOUR REASON OF VISIT

☐Scan review (Post MRI) ☐Follow up post injection (Date of injection:___/___/___) ☐Follow up post physical therapy
☐Acupuncture ☐Trigger point injection ☐Flare Up ☐Other:_____

PLEASE ANSWER THE FOLLOWING:

1. Since your last visit are you: ☐**Better** ☐**Worse** ☐**Same**

2. Please circle the percent better or worse: 0 10 20 30 40 50 60 70 80 90 100%

3. Are you in Physical Therapy? ☐Yes ☐No ☐Completed
Where:_____ Number of sessions completed:_____

4. Do you have a home exercise program? ☐Yes ☐No
Hours per day:_____ Days per week:_____

5. Have you had any new surgeries? ☐Yes ☐No If yes, what and where:_____
_____

6. Please list any changes to your medications since your last visit:_____
_____

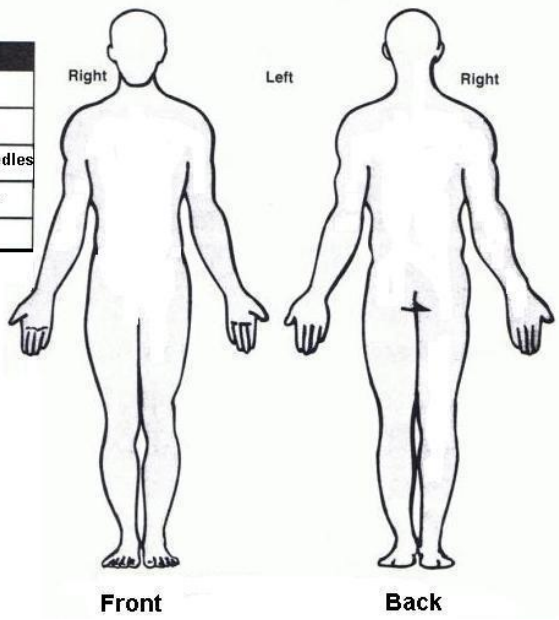
7. Have there been any major changes in your medical history since your last visit? ☐**Yes** ☐**No**
If yes, please list changes here:_____

8. Have you had any medical tests, ordered by another physician, since your last visit? ☐**Yes** ☐**No**
If yes, What and where were they done:_____

Instructions: Mark the drawings according to where you feel pain. (if the right side of your neck hurts, mark the drawing on the right side, ect. Please indicate which sensation you feel by using the key below.

☐RIGHT HANDED
☐LEFT HANDED

KEY
/ / / / / Stabbing
X X X X Burning
0 0 0 0 Pins & Needles
= = = = Numbness
+ + + + Aching



Rate your pain
Please circle your pain level 0=no pain
10=Extreme pain

1. Right now: 0 1 2 3 4 5 6 7 8 9 10

2. At best: 0 1 2 3 4 5 6 7 8 9 10

3. At worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your pain better?

What makes your pain worse?