

MA USE:

Lst MRI:

Lst Inj (Date, Type, Results):

PT:(How many wks?):

Anti-Inflammatoies (Name, How Long?):

THE PHYSIATRY MEDICAL GROUP

Name:

MR#:

E-MAIL:

Dr. Jeffrey Saal Dr. Joel Saal Dr. Robert Gamburd **DOB:**

DATE:

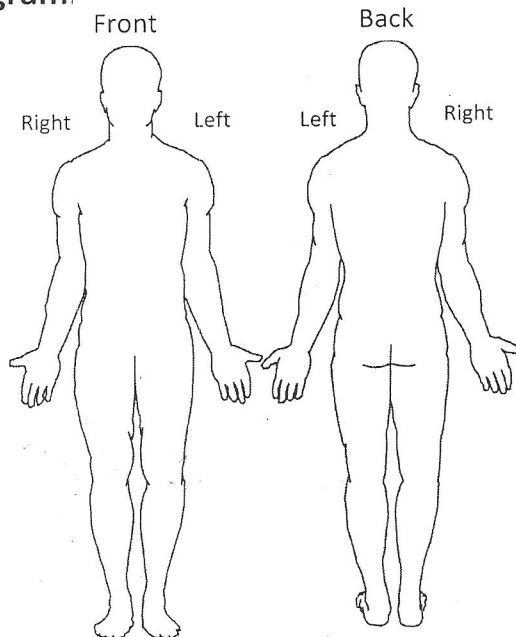
Dr. Gearld Keane Dr. Robert Millard Dr. Neeti Bathia Dr. Christopher Bonzon

FOLLOW UP FOR: (CIRCLE ONE)

MRI EMG US Follow Up ACU Follow Up Post Inj Flared (Date):

1. Since your last visit are you: Better Worse Same
2. Percent Better or Worse: 0 10 20 30 40 50 60 70 80 90 100%
3. Currently in Physical Therapy? Yes No Completed
4. Home Exercise Program? Yes No
5. Have you had any new surgeries? Yes No
6. Have you had any changes in your medications since your last visit? Yes No
7. Have there been any changes in your medical history since your last visit? Yes No

Please Complete Diagram:



Key:

- ///-Stabbing
- XXX-Burning
- OOO-Pins and Needles 3.
- ===-Numbness
- +++Aching
- TTT-Weakness

Rate Your Pain

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
- At Worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your pain better?

- Ice Medication Heat
- Stretching Other

What Makes Your Pain Worse?

- Stretching Standing Sitting
- Bending/Twisting Other