Patient Name: _____ *Follow Up Medical History Intake Form*
Date of Birth: ____/____/____ MR#: **Today's Date____/____/___**

Since your last physician visit, are your symptoms …	Better	Worse	Same

If better, by how much on a scale of 0-100%? (if 0 was the way you were and 100% was completely normal) _____%

What do you want to accomplish from today's visit?

Diagnosis	Treatment Options	X-ray Rx	MRI Rx	Med Rx	Injection Rx	Review Test

Where do you have pain or a problem (which body part)?

Does the pain travel or radiate?	Yes	No	

What makes it *worse*?	walking	sitting	standing	lying down	exercise	Other:

Please make a *mark on the line* below to indicate the level of pain or discomfort you have today.

No Pain ——————————————————————— Worst Pain Ever
0 1 2 3 4 5 6 7 8 9 10

Any change in your health status that we should be aware of?	Yes	No
Unexplained weight loss?	Yes	No
Loss of control of stools?	Yes	No

Please draw where you have Pain