Patient Name: _____ *Follow Up Medical History Intake Form*
Date of Birth: ____/____/____ **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?

☐ diagsnosis ☐ Treatment options ☐ X-ray Script ☐ MRI Script ☐ Medication ☐ Injection ☐ Review Test

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

Does the pain travel or radiate?	◯ Yes	◯ No	**Where does it radiate to?**

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

Please 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 bladder or stools?	◯ Yes	◯ No

Please draw where you have Pain