Rehabilitation Physicians of Pittsburgh

Follow-Up Form

OFFICE USE ONLY

Date	H	W	BP	Pulse

PATIENT INFORMATION

Last Name, First Name	DOB	Age	Height	Weight	Dominant Hand

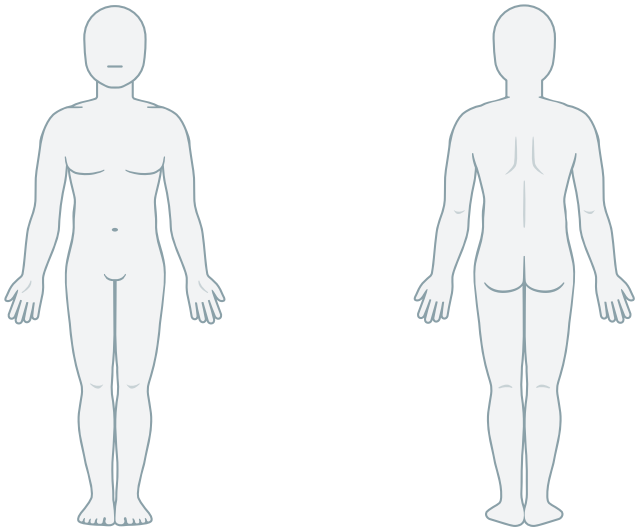
REASON FOR VISIT

Please briefly describe the reason for today's visit

Is this the same issue addressed at your last visit? ☐ No ☐ Yes

Since your last visit, your symptoms are ☐ Better ☐ Worse ☐ Unchanged

Mark the areas on your body where you typically feel symptoms. Include all affected areas



Associated Symptoms

- ☐ Balance Issues
- ☐ Bruising
- ☐ Buckling
- ☐ Catching/Locking
- ☐ Chills
- ☐ Drainage
- ☐ Fever
- ☐ Grinding
- ☐ Instability
- ☐ Loss In Bowel/Bladder
- ☐ Numbness
- ☐ Popping/Clicking
- ☐ Radiation Down Arm/Leg
- ☐ Redness
- ☐ Swelling
- ☐ Tingling
- ☐ Warmth
- ☐ Weakness
- ☐ Weight Loss

Indicate your current level of discomfort/pain below

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 No pain — 10 Worst pain ever

What makes your symptoms **BETTER**?

What makes your symptoms **WORSE**?

Is the pain tolerable?

- ☐ No
- ☐ Yes
- ☐ Sometimes

Describe your symptoms (check all that apply)

- ☐ Aching
- ☐ Burning
- ☐ Deep
- ☐ Dull
- ☐ Sharp
- ☐ Stabbing
- ☐ Superficial
- ☐ Throbbing
- ☐ Other_____

Your symptoms are

- ☐ Occasional
- ☐ Frequent
- ☐ Constant
- ☐ Worsening
- ☐ Improving

Today, your level of discomfort/pain is

- ☐ No Pain
- ☐ Mild
- ☐ Moderate
- ☐ Severe

Have you had any of the following treatments since your last office visit? (check all that apply)

- ☐ None
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Injection
- ☐ Massage
- ☐ Occupational Therapy
- ☐ Physical Therapy

Number of sessions: _____

What medications are you currently taking for your symptoms? (Include OTC's, supplements, vitamins, herbals)

How many are you taking per day?

Are you experiencing any medication side effects?

What are you doing for exercise?

REVIEW OF SYSTEMS

☐ None of the below

Check all symptoms that apply

- ☐ Abdominal pain
- ☐ Anxiety
- ☐ Balance problems
- ☐ Black stools
- ☐ Change in appetite
- ☐ Chest pain
- ☐ Chest palpitations
- ☐ Depressed mood
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Dizziness
- ☐ Double/blurry vision
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Fatigue
- ☐ Fevers
- ☐ Frequent nose bleeds
- ☐ General morning stiffness
- ☐ Headache
- ☐ Heartburn
- ☐ High blood pressure
- ☐ Increased thirst
- ☐ Jaundice
- ☐ Limb or joint swelling
- ☐ Loss in bowel/bladder
- ☐ Loss of hearing
- ☐ Nausea/vomiting
- ☐ Night pain
- ☐ Night sweats
- ☐ Numbness/tingling
- ☐ Shortness of breath
- ☐ Skin Rash/Psoriasis
- ☐ Sleep problems
- ☐ Unexplained cough
- ☐ Unintentional weight gain/loss
- ☐ Urinary frequency/ urgency
- ☐ Vision changes
- ☐ Wheezing

CHANGES TO MEDICAL HISTORY

☐ No Changes

Please only fill in any NEW information since your last visit with us

Have there been any changes to your medications? Include both newly prescribed and discontinued.

Do you have any new medication allergies?

Have you had any medical testing since your last visit with us (X-Ray, MRI, EKG, etc.)?

Have there been any changes to your family history?

Are you currently working? ☐ Regular Duty ☐ Modified Duty ☐ Not working: _____

Job Title: _____ Date you last worked: _____

ADDITIONAL INFORMATION

Is there anything else you would like us to know?

This form contains accurate information and was completed to the best of my knowledge.

Patient/Responsible Party Signature

Date