Orthopaedic and Spine Center of New Jersey

FOLLOW UP SHEET

Patient Name _____ Current **Age**: _____ Date _____

Today's **Major/Chief Complaint** (please provide exact description):_____

_____

Current Medications (please include dosages & frequency if known): _____

_____

_____

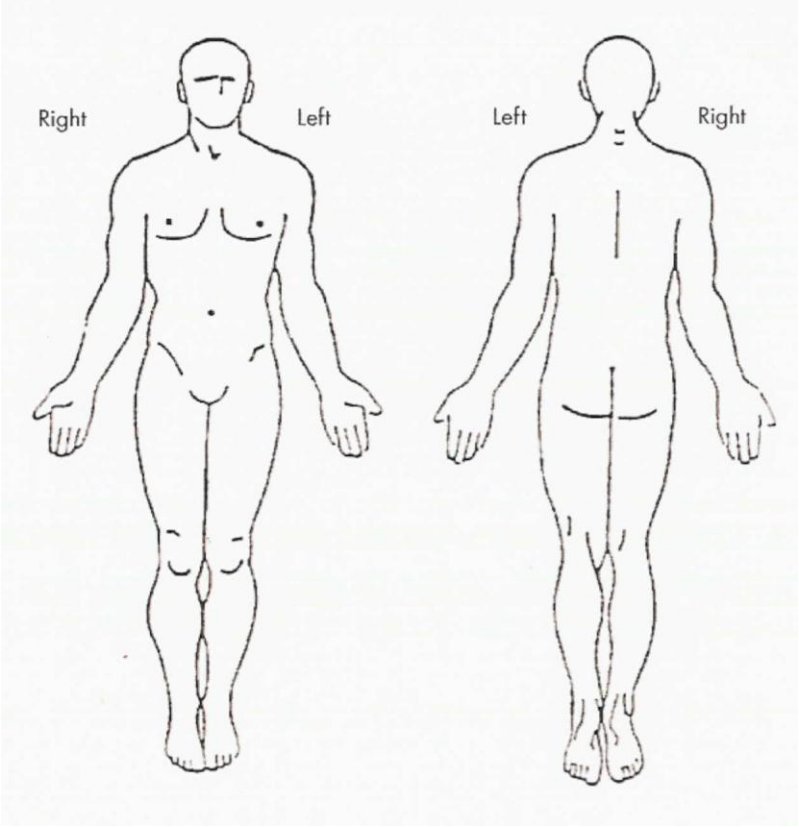
List any **medication allergies** (and your reaction to each): _____

_____

Is the Condition ( )Improving ( )Unchanged ( )Worsened

Please complete the pain diagram below

(Where is your pain? Please mark on the drawing where you feel pain right now and use the key below the figures)



PINS & NEEDLES → ***OOOOO*** **BURNING** → ***XXXXX***
STABBING → ***////////*** **DEEP ACHE** → ***ZZZZZ***
NUMBNESS→ **********

Percentage of Pain:

Back _____ + Leg _____ → = Total 100%
Neck _____ + Arm _____ → = Total 100%

Rate pain on a scale of 0 to 10

(0 = no pain → 10 = most severe pain imaginable)
Back ____ Buttock ____ Groin ____ Thigh _____
Neck ____ Shoulder ___ Calf _____ Foot _____
Arm ____ Hand ____

How long have the problem(s)/symptom(s) been present? ____ Day(s) ____ Wk(s) _____ Mo.(s) ____ Yr(s)

What makes symptoms worse?

( ) Bending ( ) Sitting ( ) Rising ( ) Standing
( ) Walking ( ) Lying ( ) Stationary ( ) On the move
( ) A.M. ( ) As day progresses ( ) P.M. ( ) Driving
( ) Other:
_____

What makes symptoms better?

( ) Bending ( ) Sitting ( ) Rising ( ) Standing
( ) Walking ( ) Lying ( ) Stationary
( ) On the move ( ) Other:
_____

Overall, rate your pain (0 = no pain → 10 = extreme pain)

- At its Worst: 0 1 2 3 4 5 6 7 8 9 10
- At its Best: 0 1 2 3 4 5 6 7 8 9 10
- Right Now: 0 1 2 3 4 5 6 7 8 9 10

Are you currently receiving: (please circle)

Physical Therapy → It is: **Helping** **Hurting** **Not making a difference**

Chiropractic Treatment → It is: **Helping** **Hurting** **Not making a difference**

IF THERE ARE NO CHANGES IN ANYTHING BELOW PLEASE CHECK HERE ☐

New Medical Problems:_____

Social History
( ) Single ( ) Married ( ) Divorced ( ) Widow/Widower ( ) Nonsmoker
( ) Smoker _____ (packs per day)
Alcohol Consumption → ( ) Never ( ) Occasionally ( ) Frequently
( ) Working → Working As: _____

Family History : Does anyone in your family have any of the following problems?
( ) Heart Disease ( ) Diabetes ( ) High Blood Pressure ( ) Cancer
( ) Nerve Problems ( ) Arthritis
Other _____

Past Surgeries/Procedures (list all and approximate date)_____/_____/_____

_____/_____/_____

Review of Systems: Please circle / note any changes in the body areas / organs listed below
Eyes: Double vision Blurring Glasses/Contacts Others:
ENT (Ears,Nose,Throat): Loss of hearing Hearing Aid Sinusitis Hoarseness Vertigo Tinnitus
Heart: Chest pains Palpitations Murmurs High blood pressure Others:
Lungs: Asthma Shortness of breath Cough Emphysema COPD
GI: Stomach Bowels Diarrhea Constipation Weight loss Appetite
GU: Kidneys Bladder Incontinence Painful urination
Muscle/Skeletal: Muscles Joints
Skin: Rashes Ulcers Masses Scars
Neurological: Coordination Weakness Visual changes Changes in sensation Balance
Psychiatric: Depression Sleep disturbances Mood swings Hallucinations
Endocrine: Growth changes Hair changes Hyperactivity Hypoactivity
Hem / Lymph: Bleeding Anemia Lymph node swelling
Allergic:

PATIENT SIGNATURE:_____

THIS FORM ONLY USED TO RECORD CHANGES TO ORIGINAL HISTORY

8/6/12