

# Follow-up Patient Intake Form

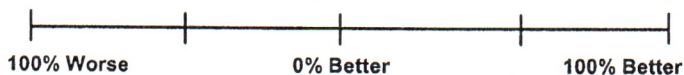
Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

What is your primary complaint today?  
\_\_\_\_\_

What are your goals for today's visit?  
\_\_\_\_\_

Since your last visit, do you feel...?



Have you had any other medical, social or family changes since we last saw you?  Yes  No  
Please explain:  
\_\_\_\_\_

Any diagnostic tests since your last visit?  No

X-Ray  CT scan  MRI  EMG  Other

Date(s) of tests(s): \_\_\_\_\_

Where done: \_\_\_\_\_

Any new treatments since last visit?  No

- Physical Therapy
- Chiropractor
- Acupuncture
- Psychological counseling
- Other \_\_\_\_\_
- Home exercises
- Injection/Nerve blocks
- Type: \_\_\_\_\_
- Massage
- TENS Unit

Any medication changes?  No  Yes

NAME	DOSE	FREQUENCY

### Description:

Is your pain:  constant  intermittent

What makes your pain better?  
\_\_\_\_\_

What makes your pain worse?  
\_\_\_\_\_

Do you have any numbness?  No  Yes

Please describe: \_\_\_\_\_

Do you have any weakness?  No  Yes

Please describe: \_\_\_\_\_

## Review of Systems:

Are you currently experiencing any of the following conditions?

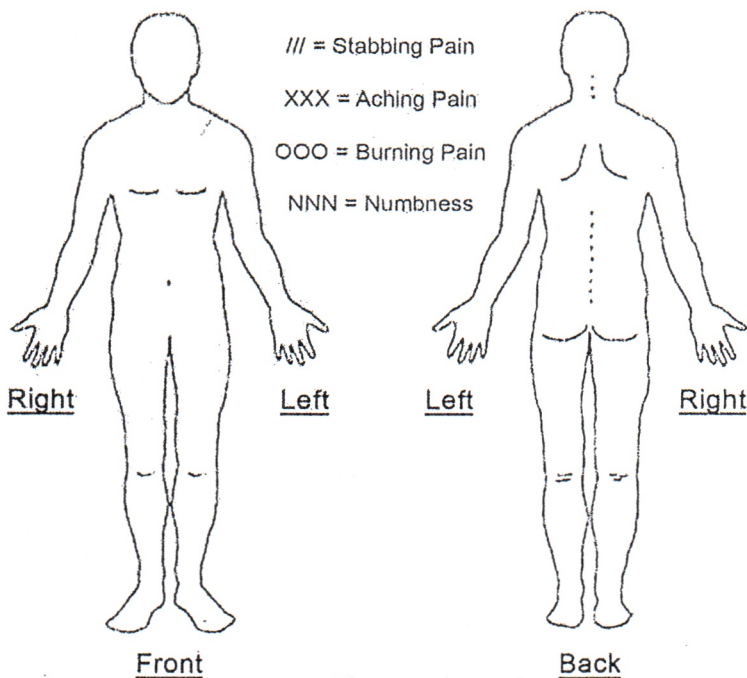
- Fever
- Chills
- Cough
- Shortness of breath
- Sore throat
- Chest pain
- Palpitations
- Constipation
- Diarrhea
- Abdominal pain
- Headache
- Balance problems
- Rash
- Joint swelling
- Incontinence
- Feeling "down"

Please list additional aches/pains:  
\_\_\_\_\_  
\_\_\_\_\_

Any new providers in your care?  No  Yes

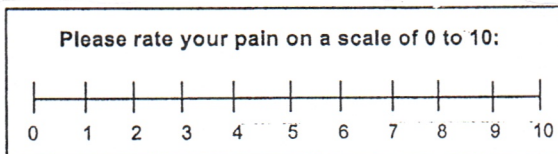
Name(s) and phone number(s):  
\_\_\_\_\_  
\_\_\_\_\_

Please draw your pain on the diagrams below. Use the corresponding symbols to show the type and location of pain you feel.



I hereby acknowledge that I have had the opportunity to review and/or receive a copy of the HIPPA Notice of Privacy Practices for Michelle Pepper, MD (available at front desk).

Patient Signature: \_\_\_\_\_



Reviewed with patient by: \_\_\_\_\_ On date: \_\_\_\_\_