SSR - Patient Follow Up Form

Name ______________________________ DOB ________________ Date __________________

Please complete the following questions based on your condition today :

*Have you had any imaging since your last visit? **MRI CT XRAY** If so, where was it performed? ___________

*How many sessions of PT since last visit? ____ Since therapy, which of the following apply: **Improved Worsened Unchanged**

*If currently taking medication, what is the name?___________ Medication has **Improved Worsened Unchanged** pain.

*Where is your pain located? **Neck Mid back Low back Shoulder Elbow Hand Hip Knee Ankle**

*Which side is your pain located? **Left Right Both**

*Does your pain radiate? **Yes No** If yes, where? ______________________________

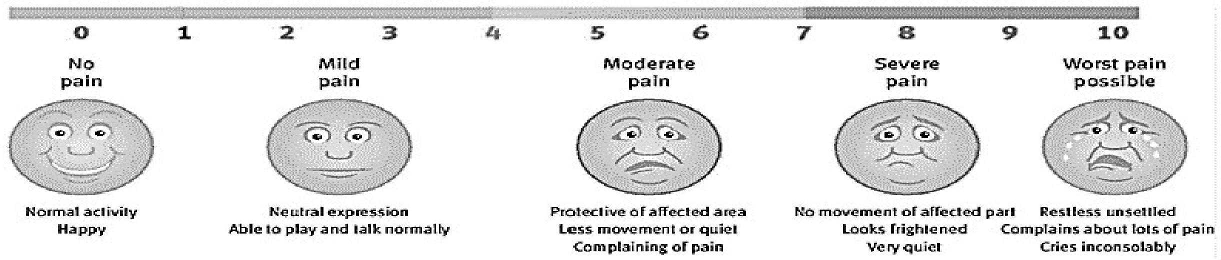
*Pain is: **Improved Worse Unchanged**

*If better, how much IMPROVED? _______%

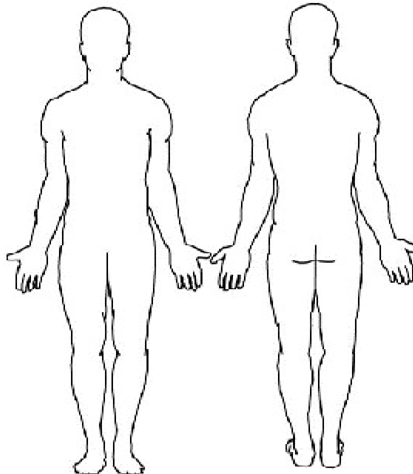
*If worse, how have your symptoms changed? ______________________________

*The pain is: RARE INTERMITTENT CONSTANT

Rate your pain on the scale below.



Please circle the location of your pain on diagram below:



*Pain is: ACHY, BURNING, STABBING, NUMB, PINS AND NEEDLES, OTHER ___________

*What makes it **Worse**? ______________________________

*What makes it **Better**? ______________________________

*Check ALL that apply:

*Associated Symptoms: **CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN BOWEL/BLADDER INCONTINENCE LEG PAIN WITH WALKING OTHER** ___________

*Other information about your problems: ______________________________

***Please list any new medication:** ____________________ NONE

Office Use Only
H: W:
BP: P:
R:
Pharmacy: