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DATE _____ **FOLLOW UP FORM** HT _____ WT _____

PATIENT NAME _____ DOB _____ AGE _____
ADDRESS _____
PHONE _____ CELL _____
INSURANCE _____
EMAIL _____
PCP NAME _____ CITY _____ STATE _____
PCP PHONE _____ PCP FX _____
PHARMACY _____ CITY _____ STATE _____
PHONE _____ FAX _____

REASON FOR VISIT _____

LIST ALL MEDICATIONS FROM ALL DOCTORS (INCLUDING OVER THE COUNTER)

MEDICATION	DOSE	FREQUENCY

LIST ALL ALLERGIES TO MEDICATIONS

CHANGE IN CLINICAL STATUS (EX. IMPROVED CONDITION, NEW CONDITION, ETC.)

_____
_____

LIST ANY LABORATORY OR RADIOLOGICAL STUDIES RECENTLY COMPLETED

_____
_____

PRESCRIPTIONS**: ***NARCOTIC PRESCRIPTIONS WILL NOT BE REPLACED IF LOST OR STOLEN
*** PATIENTS MUST REQUEST REFILLS***, WE WILL NOT RESPOND TO PHARMACY REQUESTS.
APPOINTMENTS**: **$40.00 NO SHOW FEE** INSURANCE COMPANIES ***DO NOT REIMBURSE FOR NO SHOW FEES.
***FILLING OUT FORMS**: DEPENDING ON COMPLEXITY, WE DO CHARGE BETWEEN $20 - $30 FOR COMPLETING FORMS

PATIENT/GUARDIAN SIGNATURE: _____

$ OWED _____ **$ PAID** _____ **CC CA CK#** _____ **POSTED? Y N SCANNED BY:** _____

PATIENT COMFORT ASSESSMENT

PATIENT NAME _____ DATE _____

*ORIGINAL PILL BOTTLES MUST BE BROUGHT TO ALL APPOINTMENTS

DATE OF LAST MENSTRUAL PERIOD? _____ ARE YOU PREGNANT? **YES** ☐ **NO** ☐

SELECT YOUR PAIN SINCE YOUR LAST VISIT (WHILE ON MEDICATION)

☐ **0**=NO PAIN
☐ **1-3**=MILD PAIN (MINIMAL INTERFERENCE WITH DAILY ACTIVITIES)
☐ **4-6**=MODERATE PAIN (SIGNIFICANT INTERFERENCE WITH DAILY ACTIVITIES)
☐ **7-10**=SEVERE PAIN (SOME/ALL DAILY ACTIVITIES NOT POSSIBLE)

YES **NO** IS YOUR PAIN CONTROL SATISFACTORY?

PAIN IS MADE WORSE BY: _____
PAIN IS MADE BETTER BY: _____

PAIN INTERFERENCE

Please respond to each item by marking one box per row

IN THE PAST 7 DAYS...	NOT AT ALL 1	A LITTLE BIT 2	SOME WHAT 3	QUITE A BIT 4	VERY MUCH 5
How much did pain interfere with your enjoyment of life?					
How much did pain interfere with your ability to concentrate?					
How much did pain interfere with your day to day activities?					
How much did pain interfere with your enjoyment of recreational activities?					
How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?					

IN THE PAST 7 DAYS...	NEVER 1	RARELY 2	SOMETIMES 3	OFTEN 4	ALWAYS 5
How often did pain keep you from socializing with others?					

☐ **YES** ☐ **NO** HAVE YOU SEEN ANY OTHER DOCTORS SINCE YOUR LAST VISIT?
IF YES, LIST DOCTORS SEEN _____

☐ **YES** ☐ **NO** ANY CHANGES IN YOUR MEDICATION SINCE YOUR LAST VISIT?
IF YES LIST CHANGES MADE _____

☐ **YES** ☐ **NO** ARE YOU TAKING YOUR MEDICATIONS AS DIRECTED?
IF NO, LIST REASONS WHY _____

PATIENT SIGNATURE: _____