FOLLOW-UP VISIT

1. **HAVE YOU HAD ANY NEW TEST (EXAMPLE, MRI) SINCE YOUR LAST VISIT? (INCLUDE ANY TEST THAT MIGHT HAVE BEEN ORDERED BY THIS OFFICE)**

2. **DO YOU HAVE ANY NEW PROBLEMS SINCE YOUR LAST VISIT?**
   Yes or No.
   If yes, explain:

3. **HAVE YOU BEEN PRESCRIBED ANY NEW MEDICATIONS BY ANOTHER DOCTOR'S OFFICE?**
   Yes or No.
   What kind, if any?

4. **ARE THE MEDICATIONS PRESCRIBED BY THIS OFFICE HELPING?**
   Yes or No.
   If yes, explain:

5. **ARE THERE ANY SIDE EFFECTS FROM THE MEDICATIONS?**
   Yes or No.
   If yes, explain:

6. **HAVE YOU TRIED ANY NEW REMEDY FOR YOUR PAIN? INCLUDE OVER-THE-COUNTER MEDICATIONS SUCH AS ADVIL, NERVE BLOCKS, PHYSICAL ACTIVITY SUCH AS STETCHING, CHIROPRACTIC OR PHYSICAL THERAPY.**
   Yes or No.
   If yes, explain:

7. **HAS YOUR LEVEL OF PHYSICAL ACTIVITY INCREASED, DECREASED, OR STAYED THE SAME SINCE YOUR LAST VISIT?**

8. **ARE YOU PRESENTLY WORKING, IF SO HAS YOUR DUTIES CHANGED?**
   Yes or No.

9. **ON A SCALE OF 0-10, WHAT IS YOUR PAIN LEVEL NOW? ______**

10. **WHAT HAS BEEN YOUR AVERAGE PAIN LEVEL (0-10) OVER THE LAST WEEK? _____**

11. **OVERALL, IS YOUR PAIN GETTING:**
    a) BETTER
    b) WORSE
    c) SAME