

The Spine and Orthopedic Center
RETURN VISIT PATIENT HISTORY
Michael Kenly, MD

PATIENT _____ DOB _____ Today's Date _____

Reason for follow-up visit: (Circle all that apply.)

- Pharmacologic pain management Due to recurring symptoms For a new problem After an injection
After diagnostic testing After starting physical therapy To discuss treatment options

Generally speaking, how are your symptoms? (Circle one) Better Worse Same

Describe any symptom changes since your last visit: _____

Have any medications changed since your last visit? (Circle one): Yes No

If yes, please describe changes: _____

Describe the effect of your current pain medications: (Check all that apply)

- Increase my activity Cause me to be too sleepy Make it difficult to function
 Improve my sleep Have no benefit Decrease my pain level
 Causes side effects Other: _____

Explain: _____

Did you have an injection or surgery since your last visit? (Circle one) Yes No

What percentage of relief did you have from the procedure? _____%

Are you receiving physical therapy or chiropractic treatment? Yes No (circle)

If so where: _____ How many days per week: _____

What physical therapy or chiropractic treatments are you receiving? _____

Have you had any acupuncture since your last visit? Yes No (circle)

Have you had any medical tests since your last visit such as x-rays, MRI, blood tests, etc? Yes No (circle)

What and Where? _____

Have you seen any other doctors since your last visit? Yes No (circle)

What has been changed or treated? _____

Have you been treated at a hospital since your last visit? Yes No (circle)

Please explain: _____

Check all that apply since your last visit: None apply:

- Stomach pain
- Urinary incontinence
- Bowel incontinence
- Fever or chills
- Thoughts of hurting myself or others
- Nausea or vomiting
- Frequent diarrhea
- Seizures
- Swollen ankles or legs
- Frequent Constipation
- Frequent headaches
- Bleeding w/bowel movements
- Unintentional weight loss
- Other: _____

Circle the number that best describes your CURRENT PAIN with "10" being the most severe.

Back/Leg 0 1 2 3 4 5 6 7 9 10 Neck/Arm 0 1 2 3 4 5 6 7 9 10

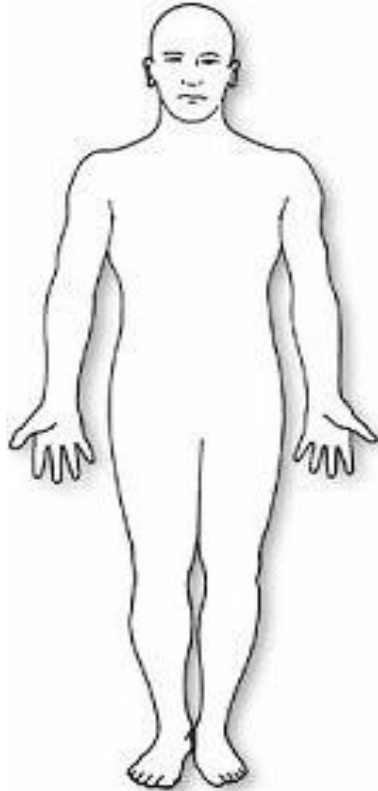
Circle the number that best describes your AVERAGE DAILY PAIN with "10" being the most severe.

Back/Leg 0 1 2 3 4 5 6 7 9 10 Neck/Arm 0 1 2 3 4 5 6 7 9 10

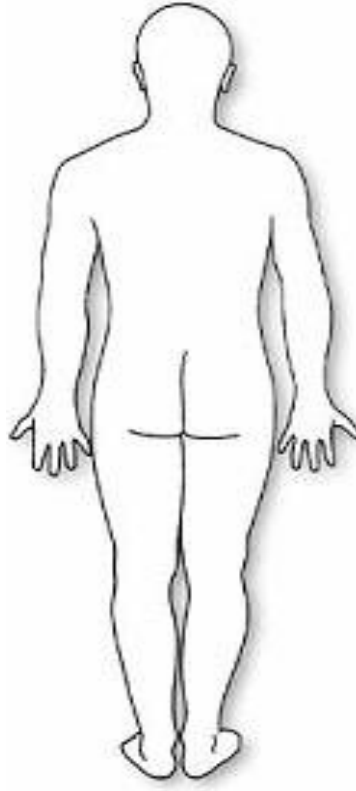
Mark these drawings using the symbols that best describe your pain:

- Numbness =====
- Stabbing //////////////
- Aching ^ ^ ^ ^ ^ ^
- Burning x x x x x x
- Pins and needles o o o o o o o
- Cramping ● ● ● ● ● ● ●

FRONT



BACK



Any additional comments: _____
