

# SALT LAKE SPINE & SPORTS MEDICINE

Brent J. Bowen, M.D., P.C. – Richard W. Hurst, M.D. – Stephen M. Clements, MPAS, P.A. –C

FOLLOW UP

## FOLLOW-UP EVALUATION FORM

Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Has your address changed? Yes No New Address \_\_\_\_\_

Has your insurance changed? Yes No New Insurance \_\_\_\_\_

Birthday \_\_\_\_\_ Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

What would you like to discuss with the doctor today? \_\_\_\_\_

Describe the **MAIN AREA OF PAIN** for which you are being seen today:

How intense is your pain currently? (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

Overall, is your pain: Getting better Getting worse About the same

Are you attending physical therapy? No Yes → Where: \_\_\_\_\_

Are you presently working? No Yes → How many hours per day? \_\_\_\_\_ On work restrictions? No Yes

Please list *new medications since last visit*:

Name	Dose	How Many/ How Often
		/
		/
		/

**Since your last visit what additional treatments have you tried?**

Medications No Yes → Describe: \_\_\_\_\_

Injections No Yes → Describe: \_\_\_\_\_

Chiropractic No Yes → Describe: \_\_\_\_\_

Other No Yes → Describe: \_\_\_\_\_

Other No Yes → Describe: \_\_\_\_\_

**Since your last visit have you experienced any new:**

Fever or chills Yes No

Rash Yes No

Loss of control of bladder or bowel Yes No

Weakness Yes No

Numbness/Tingling Yes No

Swelling or fluid on the joint Yes No

Significant weight changes Yes No

Constipation Yes No

Number of bowel movements per day \_\_\_\_\_

Please continue to the next page:

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Using these symbols, use the diagram to mark where you feel your pain.

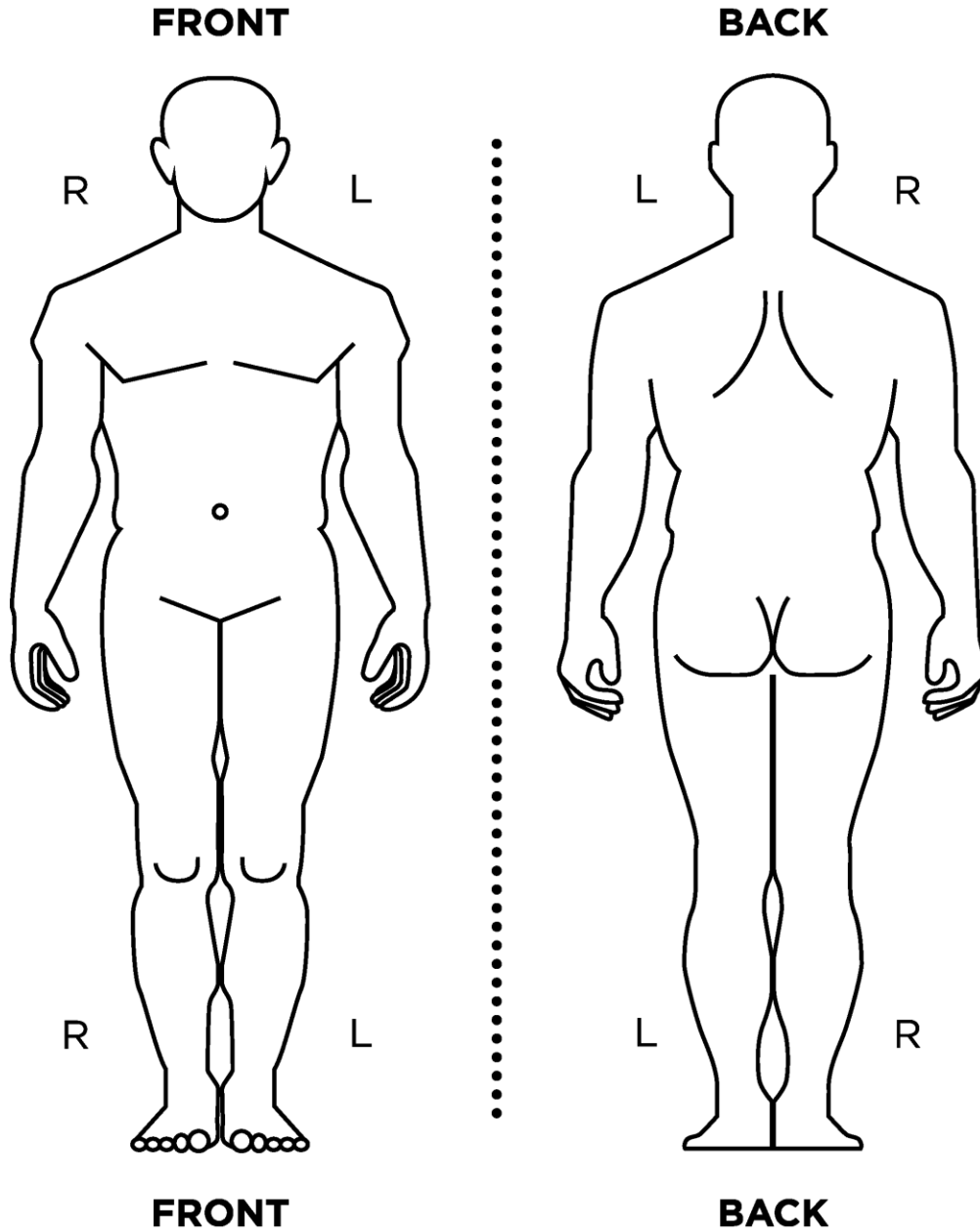
">>>>" for aching pain

"XXXX" for burning pain

"/////" for stabbing pain

"OOOO" for numbness/tingling

"SSSS" for other. Describe other: \_\_\_\_\_



Please submit this completed form by clicking "submit by email."  
You may also print them for your own records.

Thank you.