SALT LAKE SPINE & SPORTS MEDICINE

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

RETURN VISIT EVALUATION

Name: _____ **Date:** _____

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? (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

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 *current* medications:

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

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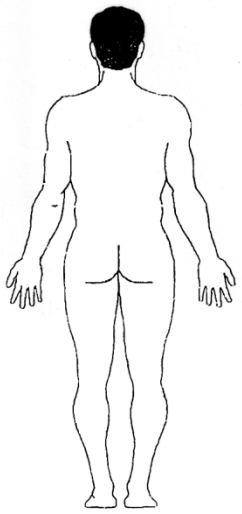
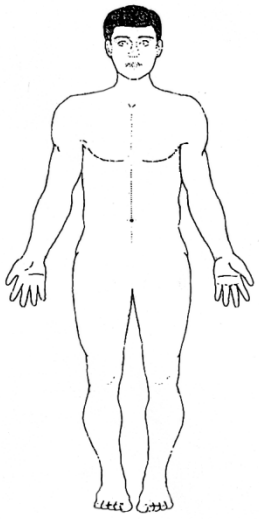
Using the symbols below, please mark all of the affected areas where you feel the described sensations.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
σ	— — —	O	X	/	●





Please note that several doctors work in each exam corridor and they see their patients in the order of their appointments. If a patient (who arrived after you) is called before you, they are not seeing your physician.