Established Patient Form

Preferred name: _____ **Age:** _____

Height: _____ **Weight:** _____

Patient is here to discuss: _____

Since your last visit, are your symptoms? ☐ Better ☐ Worse ☐ No change

Severity of pain (circle one): 0 1 2 3 4 5 6 7 8 9 10

Enrolled in Physical Therapy? ☐ Yes ☐ No **Is it helpful?** _____

If yes, where are you doing Physical Therapy? _____

What medications are you taking for pain? _____

Do they help? ☐ Yes ☐ No _____

Have you had numbness/tingling? ☐ Yes ☐ No

Changes in your medical history since last visit? ☐ Yes ☐ No **If yes** _____

New medications or changes to your medications since your last visit? ☐ Yes ☐ No **If yes** _____

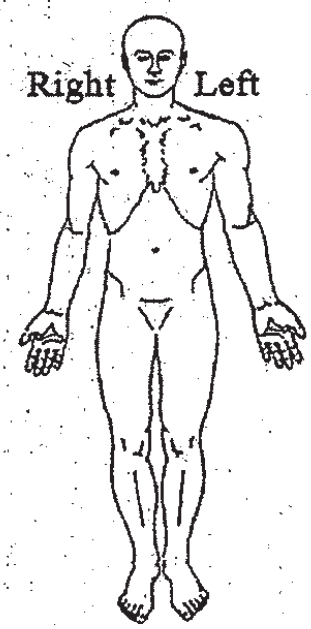
Preferred pharmacy - name and location: _____ **Phone:** _____

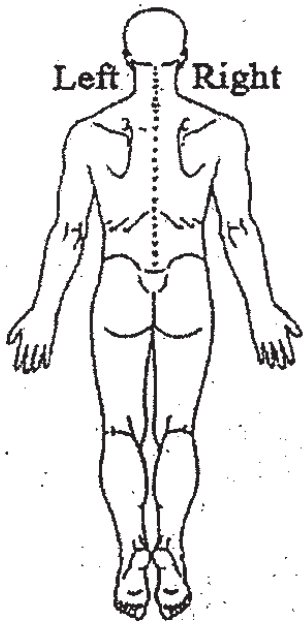
Adult patients, do you use tobacco (smoke/vape/dip)? ☐ Yes ☐ No _____ **Packs/Day**

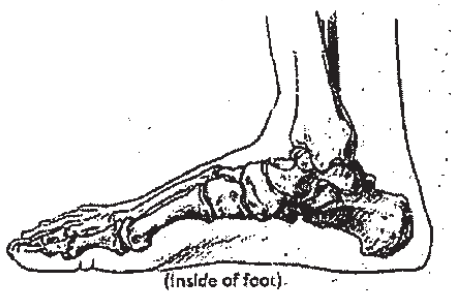
Are you on any blood thinners or herbal supplements? ☐ None ☐ Aspirin ☐ Pradaxa ☐ Plavix ☐ Xarelto
☐ Coumadin/Warfarin ☐ Anti-inflammatories/(NSAIDs) ☐ Eliquis ☐ Fish Oil ☐ Ginkgo ☐ Ginseng ☐ Other

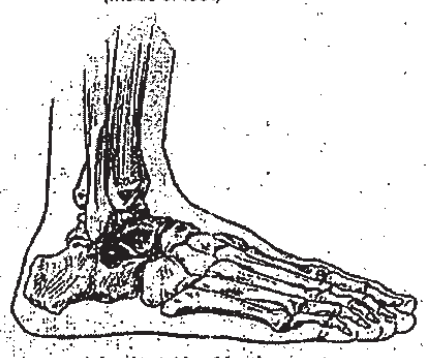
Is there a worker's compensation claim and/or a lawyer or lawsuit associated with the complaint? ☐ Yes ☐ No

Please draw where your pain is located on the diagrams below:









Name of person completing form: _____ **Relationship to patient:** ☐ Self ☐ Parent ☐ Guardia

Signature of patient, parent, or legal guardian: _____ **Date:** / /

Signature of physician: _____ **Date:** / /