Silver State Spinecare FOLLOW-UP VISIT

Name: _____ Date: _____

Mark the amount of Improvement since your last visit:

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

How have your Symptoms changed since your last visit: _____

What is your current pain level: (0-10): _____

Current work status: _____

Are you taking Medication for this condition: ☐ Yes ☐ No If YES, list name and amount per day:

_____

Are you currently in Physical Therapy or Chiropractic: ☐ Yes ☐ No Helpful: ☐ Yes ☐ No

Where? _____

Are you doing a Home Exercise Program: ☐ Yes ☐ No

Has your ADDRESS or INSURANCE information changed since your last visit: ☐ Yes ☐ No

Who is your current Primary Care Physician: _____

Please fill out the drawing and indicate your current symptoms using the symbols below:

Stabbing Pain: / / /

Numbness: ~ ~ ~

Pins and Needles: ^ ^ ^

Burning Pain: O O O

Aching Pain: X X X