



Dynamic Sports Medicine and Pain
Intake Follow Up Form

Heart Rate:
Blood Pressure:

Name: _____ Date: _____
Height: _____ Weight: _____

Reason for today's visit: Med Refill Injection Follow up injection
 MRI/CT Review

Have you had any MRI's/Ct's done since your last visit? if so, where? _____

What is your major complaint? _____

Duration of pain (since it began) _____ Is your pain: Constant Ocasional

Any changes in medication: YES NO If so, Where to? (Pleas state where & if it is left or right side)

Please describe your pain: Aching Cramping Dull Hot/Burning
 Numbing Pins & Needles Pressure-like Sharp Shooting
 Stabbing Throbbing Tingling

Rate your pain that best describes your pain at it's **WORST**(circle one): No pain 1 2 3 4 5 6 7 8 9 10(Excruciating)

Rate your pain that best describes your pain at it's **LEAST**(circle one): No pain 1 2 3 4 5 6 7 8 9 10(Excruciating)

Rate your pain that best describes your pain at it's **AVERAGE**(circle one): No pain 1 2 3 4 5 6 7 8 9 10(Excruciating)

Rate your pain that best describes your pain **RIGHT NOW**(circle one): No pain 1 2 3 4 5 6 7 8 9 10(Excruciating)

What makes your pain worse: Bending Changing Positions Coughing
 Going up stairs Heat Increased Activity Lying Flat Lifting
 Movement Sitting a long time Sneezing Standing a long time
 Standing straight Turning Left Turning Right Walking

What makes your pain better: Assisted Devices Changing Positions Cold
 Exercise Heat Injections Lying Flat Massage Manipulation
 Medications Rest Physical Therapy Sitting Walking

Any changes in Address or Insurance? YES NO

Please **NOTIFY** if you have any changes in address or insurance!

Thank you for your cooperation, we will be with you shortly.