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.