MUSCULOSKELETAL FOLLOW-UP

Demographics

Patient Name: ___________________________ Date of Consultation: _______________________

DOB: __________________ Sex: ________ Age: ________ Handedness: L *or* R *or* Both

Injury Information

Chief Complaint (describe the problem that brings you into the office today):

____

____

Where is the pain located (e.g., front of shoulder)**?** ______________________________________

Severity
On a scale from 0 to 10 (0 = no pain, 10 = severe pain), please rate your pain:
Currently: ____/10
My pain is: • getting better • worsening • not changed since I began treatment.

Duration/Timing
How long does your pain last? __________________________________
My pain is • constant • intermittent (comes and goes)
My pain is worse: • in the morning • afternoon • evening • overnight • during activity
• after activity ☐ after I'm inactive/immobile

What has happened since we last saw you: ____

Are you currently doing Physical Therapy? ☐ Yes (___x/week) at ____________________
☐ No

Modifying Factors:

	Helping	Not Helping
ICE	☐	☐
PT (Physical Therapy)	☐	☐
Brace	☐	☐
Medication	☐	☐
Other : _________________________ _________________________	☐	☐

Associated Symptoms

Do you experience any of the following symptoms with your pain:

- Numbness
- Tingling
- Weakness
- Sensitive to light touch
- Locking
- Catching
- Give Way/Instability
- Swelling
- Popping/Cracking
- Other: ________________
- Other: ________________
- Other: ________________

Medications (prescription and over-the-counter. Please include name, dose, frequency)

____
____
____

Allergies to Medications, Foods, Contrast Agents (include reaction)

____

Review of Systems

Recently, have you experienced any of the following:

- Fever/chills
- Nausea/vomiting
- Diarrhea/constipation/abdominal pain
- Chest pain
- Cough
- Headache/dizziness/loss of conscience
- Sore throat/Earache
- Vision changes
- Fatigue
- Weakness/Numbness
- Weight loss
- Weight gain
- Night pain
- Urinary Frequency
- Back pain
- Joint pain
- Rashes
- Shortness of breath
- Other: _____________
- Other: _____________

Patient Signature ______________________________________ Date ___________________

Thank you for completing this questionnaire. It will help us to serve you better.

Physician Signature _____________________________________ Date ___________________