AXIS SPINE CLINIC

Follow-up FORM

Appt Date:_____ Name:_____ Age:____ Gender: M / F Ht:_____ Wt:_____

Reason for visit: *(circle all that apply)*
Postop care Follow-up Problem New problem

Date of surgery: _____ Type of Surgery: _____

Tobacco use: Y N *How much?* _____ Has your insurance carrier changed? Y N
Drink Alcohol: Y N *How much?* _____ New insurance info_____

Since your last visit, do you feel…?

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100% Worse No Change 100% Better

Please explain:

Current pain: *(none)* 0 1 2 3 4 5 6 7 8 9 10 *(severe)*

Do you have any new numbness or weakness?
Yes No

Please explain:

Have you had any other medical, social, or family changes since we last saw you? *(circle one)* Yes No
Please explain:

Any diagnostic tests since your last visit?
(circle all that apply)
None X-Ray CT scan MRI EMG

Other:_____

Any new treatments since last visit? *(circle all that apply)*
No Physical Therapy Chiropractic Care

Acupuncture Home Exercises Massage TENS Unit

Psychological Counseling Injections/nerve blocks

Any medication changes? Yes No
List:

Is your pain: *(circle one)*
Constant Intermittent

What makes your pain better?

What makes your pain worse?

Please list any additional symptoms (fever, chills, etc):

Mark the location of your pain using the symbols given below:

NUMBNESS - X PINS/NEEDLES – 0
BURNING - / STABBING - =
ACHE - <