



PATIENT INFORMATION FORM FOR ESTABLISHED PATIENTS (Rechecks)

(PLEASE COMPLETE EVERYTHING ABOVE THE DOTTED LINE,

AND ONLY THOSE AREAS THAT HAVE CHANGED BELOW THE DOTTED LINE)

Date: _____ Name: _____ DOB: _____ Age: _____ Occupation: _____

Current Problem(s): _____

Severity (Normal = 0 -----> Excessive = 10) _____

Are you better? Yes % Better _____; Same? Yes ; Worse? Yes % Worse _____; Is there night pain? Yes No

What makes the symptoms better? _____

Worse? _____

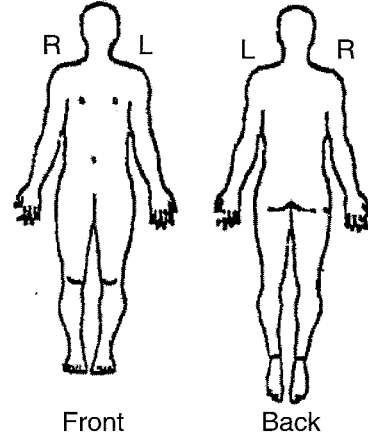
Other Associated Symptoms? _____

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What **NEW TREATMENT** and/or **MEDICATIONS** are you using now? _____

What **OTHER TESTS** have you had? _____

Where is your Pain?



Aching = ^ ^ ^ ^ ^ ^ ^ ^

Burning = -----

Stabbing = // // // // //

Numbness/Tingling = oooooo

(CHANGES FROM PREVIOUS VISIT)

PAST HISTORY: (Accidents, Illnesses, Surgeries) _____

Allergies to Medications: _____

OTHER PROBLEMS: Review of Systems		Yes	No	Yes	No
	Bladder	<input type="checkbox"/>	<input type="checkbox"/>		
Head	Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>
Throat	Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>
Chest	Muscles	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>
Heart	Bones	<input type="checkbox"/>	<input type="checkbox"/>	Appetite	<input type="checkbox"/>
Abdomen	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>
				Endocrine Glands	<input type="checkbox"/>

SOCIAL HISTORY: Are you performing your own housework? YES NO

Are you working now? YES NO If NO, Last Day Worked: _____

Full Duty Limited Duty Explain: _____

Are you participating in sports? YES NO

OTHER: _____

FOR FEMALES ONLY: COULD YOU BE PREGNANT? Yes No ARE YOU BREAST FEEDING? Yes No

Physician Signature

Patient Signature

(Do not write below this line)

Notes:
Height: _____ Weight: _____ Change from last visit: _____ BP: _____ Pulse: _____

PHYSICAL EXAMINATION: _____ ** Can use **N** for Normal

1) NAME _____ DATE _____
 RESP _____ HGT _____ WT _____ B/P _____ PULSE _____ TEMP _____

2) APPEARANCE _____
 GAIT _____
 _____ Inspection/Palpation Range-of-Motion Stability Strength and Tone

3-6) NECK _____
 & BACK _____
 RUE _____
 LUE _____
 RLE _____
 LLE _____

7) SKIN: NECK _____ BACK _____ RUE _____ LUE _____ RLE _____ LLE _____

8) COORDINATION _____
 9) REFLEXES _____
 10) SENSATION _____
 11) MENTAL STATUS _____
 12) MOOD AFFECT _____
 LANGUAGE _____
 KNOWLEDGE/MEMORY _____

13) PERIPH. PULSES, VARICOSITIES, EDEMA, ETC. _____
 14) LYMPH NODES, AXILLA, NECK AND/OR GROIN _____

TEST RESULTS:

OTHER REPORTS:

DIAGNOSES:

PLAN:

RISK OF COMPLICATIONS/SEVERITY:

INSTRUCTION/COUNSELING:

GOALS:

PROGNOSIS:

OTHER/PATIENT QUESTIONS:

2/3 Elements	99212	99213	99214	99215
HPI	1-3 Elements	1-3 Elements	4 or More	4 or More
ROS	N/A	Related to HPI	Related to HPI & 2-9 Negs.	10
PFSH	N/A	N/A	1 item from any 3 areas	1 from each of 3 areas
EXAM	Affected body area only	6 Elements	12 Elements	All Elements
DECISION MAKING (See sheets in rooms for more detail)	1 Minor problem	2 or more minor problems	2 or more stable chronic	2 or more stable chronic or 1 with exacerbation

RETURN VISIT _____ PHYSICIAN SIGNATURE _____