

## Follow Up Questionnaire

\*\*\*Development of New Allergy since last visit? No Yes, \_\_\_\_\_

**Current Pain Scale:** (circle one number)

	MILD			MODERATE				SEVERE			
NO PAIN	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN

**Please circle ONE answer for each question that applies to you:**

- **Are you working?** Not at all | modified duty | regular duty
- **Athletics?** No participation | non-contact | full participation
- **How are you feeling:** Improving | Same | Worse
- **Previous PT:** none | did not help | helped a little | helped temporarily | helped significantly
- **Previous Injections:** none | did not help | helped a little | helped temporarily | helped significantly
- **Medications:** Helping a little | helping a lot | not helping at all | upsetting stomach |  
Not taking any medications for orthopedic problems
- **Change in symptoms:** No | Yes

**Please describe any changes in your health since your last visit:**

**Please indicate if any of your medications have changed since your last visit:**