

## PATIENT FOLLOW-UP

In order for us to best serve you please provide us with the following information.

### PLEASE PRINT

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone#: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

**1. Describe your current symptoms**

\_\_\_\_\_  
\_\_\_\_\_

**2. How often do you experience your symptoms?**

- (1) Constantly (76-100% of the day)      (3) Occasionally (25-50% of the day)  
(2) Frequently (51-75% of the day)      (4) Intermittently (0-25% of the day)

**3. What describes the nature of your symptoms?**

- (1) Sharp      (3) Numb      (5) Burning  
(2) Dull ache      (4) Shooting      (6) Tingling

**4. How are your symptoms changing?**

- (1) Getting better  
(2) Not changing  
(3) Getting worse

**5. Since beginning of care, has anything aggravated the condition? \_\_\_Yes\_\_\_No**

Describe: \_\_\_\_\_

**6. Numeric Pain Rating Scale:**

(No Pain) ( )0 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7 ( )8 ( )9 ( )10 (unbearable pain)

**7. Restrictions of activities of Daily Living:**

(No limitations) ( )0 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7 ( )8 ( )9 ( )10 (totally disabled)

**8. Do you have any new symptoms? \_\_\_Yes\_\_\_No**

Describe: \_\_\_\_\_

**9. Are you satisfied with the treatment received to date?**

\_\_\_Very pleased      \_\_\_Somewhat pleased      \_\_\_Unsatisfied

**We welcome any additional comments you would like to make:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Ellen Coyne, DC, Family Chiropractor, 164 West 79<sup>th</sup> St., New York, NY 10024**

Tel: (212) 875-9780 Fax: (212) 875-0975