# RECHECK SHEET

NAME ________________________________ Chart # ____________ Date ____________

Pneumonia & Flu vaccine: ____________________________________________

What is the reason for today's visit? ____________________________________

Since your last visit, are your symptoms, Better Worse Same

Please rate your current pain level (10 is the worst): 0 1 2 3 4 5 6 7 8 9 10

**Are you having difficulties performing your activities of daily living? Yes No**

What is your current functioning level if 100% is back to your normal self? ______________

Are you experiencing any of the following symptoms? *(Please circle)*

- Numbness/Tingling
- Weakness
- Changes to bowel/bladder pattern
- Increased pain when cough/sneeze
- Diarrhea/Constipation
- Swelling
- Night Pain

Are there any changes to your medical history since your last visit? Yes No

If yes, please explain ____________________________________________

Since your last visit have you had any of the following? *(Please Circle)*

- Spinal Injections
- Facet Injections
- Sacroiliac Joint Injection
- Trigger Point Injection
- Physical Therapy
- MRI/CT Scan/EMG

If you have had injections, what is the percentage of improvement ______________?

If you have had Physical Therapy, what is the percentage of improvement ______________?

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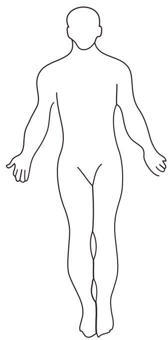
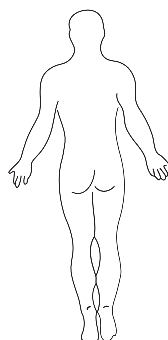


Front



Back

**On the diagram, please mark where your pain is today.**

Circle whether your pain is:

**Intermittent** or **Constant** *(Circle One)*

Circle all the words that best describe your pain:

| | | |
|---|---|---|
| Throbbing | Aching | Burning |
| Electrical | Stabbing | Dull |
| Pins and Needles | Sharp | Cramping |