

REHABILITATION MEDICINE ASSOCIATES
COLUMBIA UNIVERSITY

Follow-up Patient Questionnaire

Name: _____

Date: _____

Reason for Visit

Interval change in symptoms since last visit

Review of Symptoms

No Change

Other

Review of Symptoms	No Change	Other
Constitutional symptoms	<input type="checkbox"/>	
Head and Neck		
Skin		
Heart		
Breathing		
Stomach		
Bowel		
Bladder		
Blood		
Mood		
Sleep		
Nervous system		
Endocrine		

Has your ability to function improved with treatment?

Yes

No

Explain:

Has your pain improved with treatment?

Yes

No

Explain:

Current Medication (s)

Interval Medical change or testing (x-rays, blood tests, etc)

I am currently attending a therapy program

Yes

No

Explain:

Please rate your average pain on a scale of 0-10

Moderate

0-1-2-3-4-5-6-7-8-9-10

No Pain

Severe Pain

On diagram below please shade areas where you have pain. Place **X** where pain is severe and place **O** where there is numbness.

