

**Revisit Form**

BP: \_\_\_\_\_ / \_\_\_\_\_ HR: \_\_\_\_\_

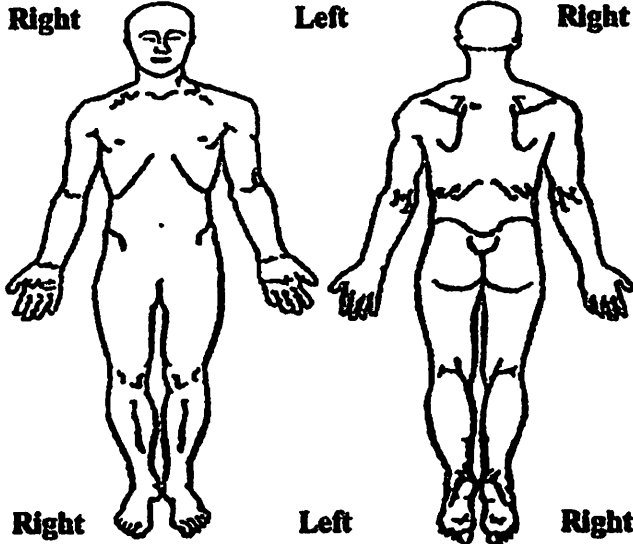
Wt: \_\_\_\_\_ Ht: \_\_\_\_\_

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Temp: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Pain Location(s): Please shade your area of pain:



Please check what qualities describe your pain:

- aching  throbbing  dull  sharp  burning
- shooting  stabbing  other: \_\_\_\_\_

Please check if you have associated symptoms:

- numbness  tingling  muscle spasm  weakness
- bowel and bladder incontinence  pins and needles  None

Indicate the number between 0-10 that best describes your pain:

0 1 2 3 4 5 6 7 8 9 10

Does your pain interfere with activities of daily living:

Not at All                      Moderately                      Severely

Does your comprehensive conservative care help decrease your pain? (i.e. Medication Management, Home Exercises, Chiropractic Care, Physical Therapy)

NO                                      YES

If you had a procedure at your last visit, did it provide 50% or more pain relief? \_\_\_\_\_ Specify pain relief %: \_\_\_\_\_

Please name medication(s) due for refill: \_\_\_\_\_

Please indicate the % of relief your medications provide and for how long: \_\_\_\_\_

Any side effects from medication(s): \_\_\_\_\_

Is there a chance that you may be pregnant? Yes / No

What worsens your pain?  coughing  straining  standing  walking  sitting  driving  touch  
 cold  bending  Other: \_\_\_\_\_

What makes your pain better?  cold  warmth  sitting  standing  medication  walking  
 changing positions  movement  laying down  rest  
 Other: \_\_\_\_\_

*Physician Notes Only*

# Revisit Form - Allergy Section

Required for all patients

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## Allergies / Bad Reactions

Do you have any allergies or bad reactions?       No known allergies       Yes       Not sure

Examples: medications, foods, latex, contrast dye, vaccines, or anything else.

If Yes or Not sure, complete below. List one allergy per line. Staff must document allergy + reaction + severity.

Allergy / Substance	Reaction - what happened? (check all that apply)	Severity (check one)
1. _____	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Trouble breathing/wheezing <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea/stomach upset <input type="checkbox"/> Other/unsure	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unsure
2. _____	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Trouble breathing/wheezing <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea/stomach upset <input type="checkbox"/> Other/unsure	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unsure
3. _____	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Trouble breathing/wheezing <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea/stomach upset <input type="checkbox"/> Other/unsure	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unsure
4. _____	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Trouble breathing/wheezing <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea/stomach upset <input type="checkbox"/> Other/unsure	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unsure
5. _____	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Swelling <input type="checkbox"/> Trouble breathing/wheezing <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea/stomach upset <input type="checkbox"/> Other/unsure	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Unsure

**Severity guide:** Mild = small rash, itching, upset stomach. Moderate = hives, swelling, worse rash, vomiting, or needed medication. Severe = trouble breathing, throat/tongue swelling, or anaphylaxis. Unsure = patient does not remember.

More than 5 allergies? Please tell staff/provider.

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**Physician Notes Only**

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Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Patient Health Questionnaire-2 (PHQ-2)

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<b>Over the last 2 weeks, how often have you been bothered by any of the following problems?</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

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Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
<b>Total Score (add your column scores) =</b>				

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### DAST-10 Questionnaire

I'm going to read you a list of questions concerning information about your potential involvement with drugs, excluding alcohol and tobacco, during the past 12 months.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

<b>These questions refer to the past 12 months.</b>	<b>No</b>	<b>Yes</b>
1. Have you used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose "No."	0	1
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	0	1

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					<b>Total</b>	