DR. MINDY GEHRS
PHYSICAL MEDICINE

Follow up questionnaire

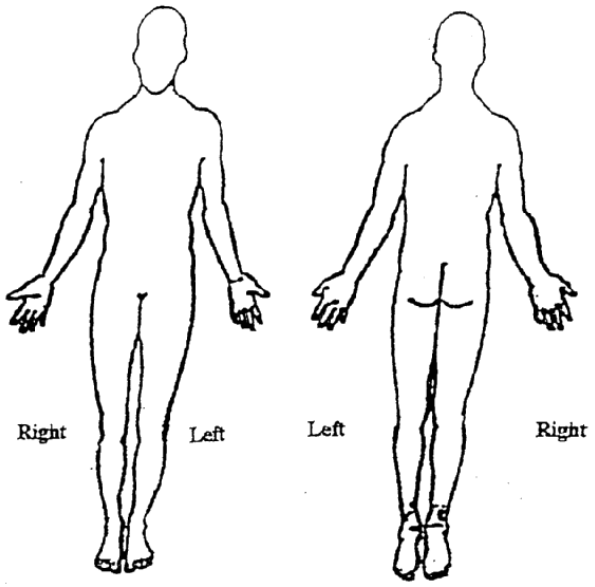
Name _____ Arrival Time: _____
Date _____

Since the last visit, I am feeling: __Same
__Better ___%
__Worse ___%

Please rate your pain on a scale of zero to ten:
0—1—2—3—4—5—6—7—8—9—10
(No pain) (Severe Pain)

New concerns: _____
_____

Specific issues you would like to address today:
_____



Please indicate on the diagram where you are currently having symptoms.

Please list all your current medications
(including over the counter medications):
******MEDICATIONS MUST BE LISTED AT EACH VISIT******
Medication How often
_____
_____
_____
_____

Problems with your current medications?
___ No ___Yes Please explain_____
_____

How often are you doing your home exercise program?_____
Any problems with your home exercise program?_____

Work Status:__Working full duty
__Working restricted duty
__Off work(restricted duty not available)
__Off work(other reason)

Please bring a list of your medications and a copy of your exercise sheets to each visit.