

**PATIENT INFORMATION FORM FOR ESTABLISHED PATIENTS (Rechecks)**  
 (PLEASE COMPLETE EVERYTHING ABOVE THE DOTTED LINE,  
 AND ONLY THOSE AREAS THAT HAVE CHANGED BELOW THE DOTTED LINE)

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current Problem(s): \_\_\_\_\_

Severity (Normal = 0 -----> Excessive = 10) \_\_\_\_\_

Are you better? Yes  % Better \_\_\_\_\_; Same? Yes ; Worse? Yes  % Worse \_\_\_\_\_; Is there night pain? Yes  No

What makes the symptoms better? \_\_\_\_\_

Worse? \_\_\_\_\_

Other Associated Symptoms? \_\_\_\_\_

.....

What **NEW TREATMENT** and/or **MEDICATIONS** are you using now? \_\_\_\_\_

\_\_\_\_\_

What **OTHER TESTS** have you had? \_\_\_\_\_

**(CHANGES FROM PREVIOUS VISIT)**

**PAST HISTORY:** (Accidents, Illnesses, Surgeries) \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

<b>OTHER PROBLEMS:</b> Review of Systems		Yes	No		Yes	No			
	<u>Yes</u> <u>No</u>			Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/> <input type="checkbox"/>			Bowel	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/> <input type="checkbox"/>			Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/> <input type="checkbox"/>			Muscles	<input type="checkbox"/>	<input type="checkbox"/>	Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/> <input type="checkbox"/>			Bones	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/> <input type="checkbox"/>			Skin	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Glands	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL HISTORY:** Are you performing your own housework? YES  NO

Are you working now? YES  NO  If NO, Last Day Worked: \_\_\_\_\_

Full Duty  Limited Duty  Explain: \_\_\_\_\_

Are you participating in sports? YES  NO

**OTHER:** \_\_\_\_\_

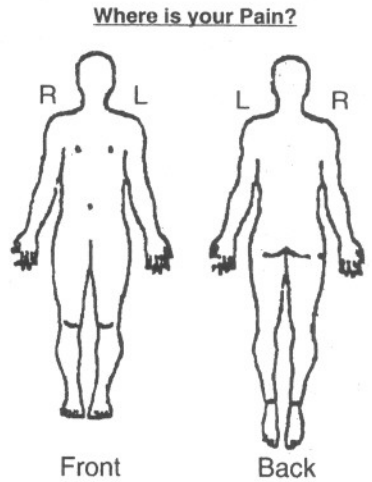
\_\_\_\_\_

Physician Signature

Patient Signature

(Do not write below this line)

**Notes:**  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Change from last visit: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_



Aching = ^ ^ ^ ^ ^ ^ ^ ^                      Burning = -----  
 Stabbing = // // // // // //                      Numbness/Tingling = oooooo

PHYSICAL EXAMINATION:

\*\* Can use **N** for Normal

- 1) NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ B/P \_\_\_\_\_ PULSE \_\_\_\_\_
- 2) APPEARANCE \_\_\_\_\_  
 GAIT \_\_\_\_\_  
     Inspection/Palpation              Range-of-Motion              Stability              Strength and Tone
- 3-6) NECK \_\_\_\_\_  
 & BACK \_\_\_\_\_  
 RUE \_\_\_\_\_  
 LUE \_\_\_\_\_  
 RLE \_\_\_\_\_  
 LLE \_\_\_\_\_
- 7) SKIN: NECK \_\_\_\_\_ BACK \_\_\_\_\_ RUE \_\_\_\_\_ LUE \_\_\_\_\_ RLE \_\_\_\_\_ LLE \_\_\_\_\_
- 8) COORDINATION \_\_\_\_\_
- 9) REFLEXES \_\_\_\_\_
- 10) SENSATION \_\_\_\_\_
- 11) MENTAL STATUS \_\_\_\_\_
- 12) MOOD AFFECT \_\_\_\_\_  
 LANGUAGE \_\_\_\_\_  
 KNOWLEDGE/MEMORY \_\_\_\_\_
- 13) PERIPH. PULSES, VARICOSITIES, EDEMA, ETC. \_\_\_\_\_
- 14) LYMPH NODES, AXILLA, NECK AND/OR GROIN \_\_\_\_\_

TEST RESULTS:

OTHER REPORTS:

DIAGNOSES:

PLAN:

RISK OF COMPLICATIONS/SEVERITY:

INSTRUCTION/COUNSELING:

GOALS:

PROGNOSIS:

OTHER/PATIENT QUESTIONS:

2/3 Elements	99212	99213	99214	99215
HPI	1-3 Elements	1-3 Elements	4 or More	4 or More
ROS	N/A	Related to HPI	Related to HPI & 2-9 Negs.	10
PFSH	N/A	N/A	1 item from any 3 areas	1 from each of 3 areas
EXAM	Affected body area only	6 Elements	12 Elements	All Elements
DECISION MAKING (See sheets in rooms for more detail)	1 Minor problem	2 or more minor problems	2 or more stable chronic	2 or more stable chronic or 1 with exacerbation

RETURN VISIT \_\_\_\_\_ PHYSICIAN SIGNATURE \_\_\_\_\_