**RETURNING PATIENT FOLLOW UP FORM**

Please fill out this brief questionnaire to assist us with your follow up visit (2 pages)

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

Patient(Guardian) email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Current Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Today’s Visit: (Chief Complaint) Please indicate below which apply

Concussion Recheck / Need Paperwork / Therapy progress / New medical problem

 Test Results/Injection/Medication Refill/ Other (Explain):

Did you take an in-office computer (CNSVS) test since your last visit?

Any of the following done since your last visit? Blood tests MRI CT XRays Bone Scan

Where were tests performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Indicate any health problems/concerns that occurred since last visit -

 hightlight or indicate all that apply)

Recent fever/weight loss Respiratory Problems (Asthma)

Eye Problems Joint/ Bone Problems

Ear, Nose, Throat issues Increased stress(family,home,school)

Blood Abnormalities (anemia, leukemia, etc.) Psychiatric or Social(behavior,depression)

Kidney Bladder problems Heart/Blood pressure problems

Thyroid problems, Diabetes Stomach/Intestinal problems

Skin Problems Allergies

Neurological Problems Headaches/Concentration Issues

Sleep disturbance Light/Sound Sensitivity

Any recent Hospitalization/ Surgery since last visit?

Where and When?

Any medication changes since last visit? List any changes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Drug Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family or Social Changes since last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*\* Please fill out this section for our clerical staff, to ensure that we can better assist the doctor in retrieving pertinent information related to today’s visit. Thank You.\*\*\**

Please Specify if a prescription and/ or paperwork will be requested at today’s visit

 (Indicate all that apply)

Medication Refill Disability/Auto/Worker’s Comp

Therapy Script Medical Leave of Absence

\*Attendant Care \*Case Management

Medical Equipment Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please include Case Manager name and email address or fax info

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Notice Regarding Collections:*

*If your account has gone to a collection agency, it is our responsibility to collect these charges. There is a 35% fee for all accounts that have been brought to collections. For Example, if your account is in collections for $75-you will be charged a total of $101.25. If you are in collections, our office will notify you at today’s visit, and attempt to collect this debt.*

**I verify that this information is accurate and will become part of my permanent medical record.**

**Patient/ Guardian Date**