**INTERVAL VISIT POST HOSPITALIZATION FORM**

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

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

Patient Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Today’s Visit: (Chief Complaint) Please circle below

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?

Please circle any of the following since your last visit: Blood tests MRI CT XRays Bone Scan

If testing done, where were tests performed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 (Circle 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 seen in hospital?

Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any medication changes since in hospital? List any changes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

New Drug Allergies ?Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family or Social Changes since hospitalization?

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

*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**