

DR. LETCHUMAN

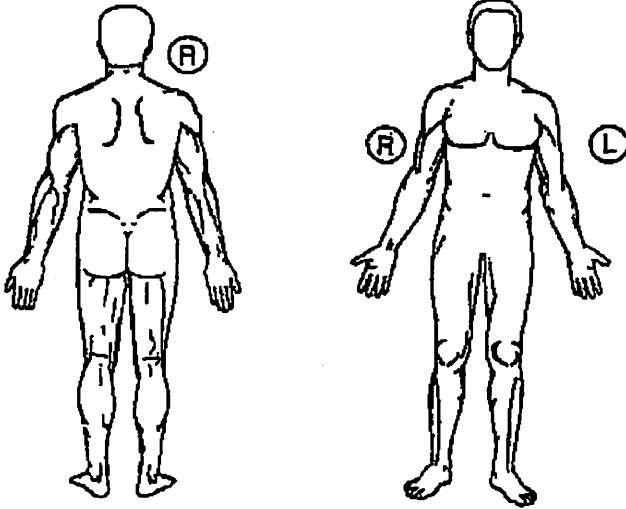
ARRIVAL TIME: _____

Follow-Up Visit Name _____ Age _____ Date _____

Primary Insurance _____ **Secondary** _____

Work Comp Yes or No **If Yes Plan Name** _____ **DOI** _____

Shade the parts of your body where you have pain:



PLEASE CIRCLE ALL THAT APPLIES:

Quality of your Pain:

Constant Achy Burning Throbbing Sharp

Since your last visit your pain is:

Better Worse Same

In the Last 4 weeks have you had:

Episodes of Sadness/Crying

Nausea/vomiting Stomach pain

Bloody-stools/Constipation

Chest pain/bloody-cough/wheezing

Pain or blood when urinating

Excessive sleepiness during the day

Disturbed sleep at bedtime

Rate your pain score while on your current treatment:

0 _____ 5 _____ 10

Please list all medications (with dosages) you are using now in order to assist the physician during your visit

Medication	Strength (Dose)	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:

Work Status: Full-time Part-time Full-duty Restricted Duty Retired Disabled Never worked

Pharmacy _____ **Address** _____ **Phone** _____

Name _____ **Physicians Notes** Date _____

PHYSICAL EXAM:

Vital Signs: Temp: _____ HR: _____ BP: _____ Height: _____ Weight: _____
Appearance: Patient appears the stated age and is in no acute distress.
Integumentary: No rash, erythema or open lesions were present in all 4 extremities.

NEUROLOGICAL

Mental Status: Alert, Oriented to person, place and time. Cooperative. Has normal attention span and concentration to carry on a meaningful conversation.
Cranial Nerves: CN2-12 grossly intact.
Motor: 5/5 strength in all 4 extremities.
Sensation: Normal to light touch in all 4 extremities.
Reflexes: DTR 2+/4 in all 4 extremities.
Tone: Normal tone in all 4 extremities. No spasticity or rigidity noted in all 4 extremities. No clonus.
Gait: Ambulates without asymmetry on level surface. Heel and toe walking normal.
Special Tests: SLR negative bilaterally when tested in sitting.

MUSCULOSKELETAL

ROM: ROM of the _____ is full range and pain free.
Palpation: Tender to palpation over _____

IMPRESSION

- 1.
- 2.
- 3.

RECOMMENDATIONS

Lab/X-Ray: CBC Chem P UDS

Other _____

Referred To: _____ Reason _____

Procedure: _____

Treating Physician 1st Available Physician Request Form Completed

Plan: _____

Med Check

One Month

Two Month

F/U: 1 2 3
 4 5 6 12
 Days Weeks Months