RETURN PATIENT QUESTIONNAIRE

Name: _______________________________________ Today's Date: _________________________________

What would you like addressed at today's visit? ____
____
____

Have your symptoms changed since the last visit? (please circle) Yes No
If yes, in what way? ____
____

Do you feel that your overall health has changed since the last visit? (please circle) Yes No
If yes, in what way? ____
____

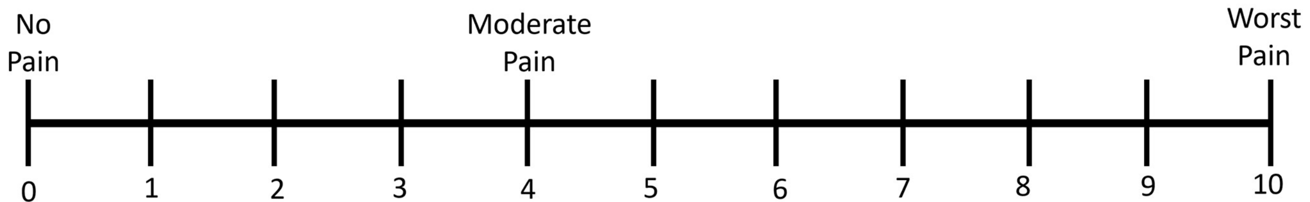
Do you feel that your function has changed since the last visit? (please circle) Yes No
If yes, in what way? ____
____

Have you had any falls since your last visit? (please circle) Yes No
If yes, describe the nature of the fall and note if any injuries were sustained ______________________________
____

Have any of your medications changed? (please circle) Yes No
If yes, please list the changes ____
____

Do you have any pain today? (please circle) Yes No

If yes, please rate your pain according to the following scale



Please list any questions you may have:
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