Injury Care Network, LLC

Provider WALLACE, D.O.
Patient ANGEL, THEODORE
DOB 09/15/1975 DOL 02/23/2023
DOS 04/07/2023

FOLLOW UP QUESTIONNAIRE

SINCE LAST VISI , I AM FE LING:

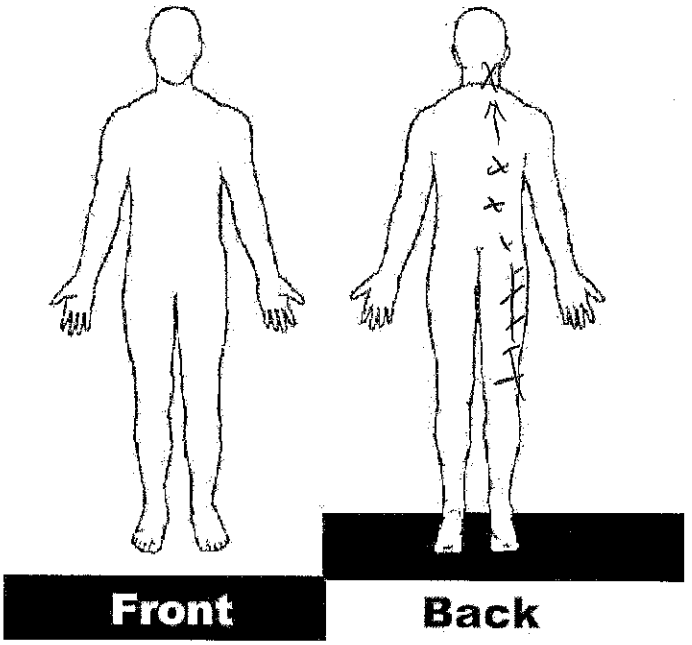
Same _ %
☐ Better _ %
☐ Worse _ %
☐

PLEASE RATE YOUR PAIN ON A SCALE OF ZERO TO TEN:

0-1-2-3-4-5-6-7-8-9-10
(NO PAIN) (SEVERE PAIN)

NEW CONCERNS: None

SPECIFIC ISSUES YOU WOULD LIKE TO ADDRESS TODAY:



PLEASE INDICATE ON THE DIAGRAM WHERE YOU ARE CURRENTLY HAVING PAIN

PLEASE LIST ALL YOUR CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER MEDICATIONS)

MEDICATION:

PROBLEMS WITH YOUR CURRENT MEDICATION?

☒ No ☐ Yes, PLEASE EXPLAIN: _____

Are you having any stomach pain? ☐ Yes ☒ No
How often are you doing your home program? _____
Any problem with your home program? _____

WORK STATUS:

☐ Working Full Duty
☒ Working Restricted Duty
☐ Off Work (Restricted Duty Not Available)
☐ Off Work (Other Reason)

PLEASE BRING A LIST OF MEDICATIONS AND A COPY OF YOUR EXERCISE SHEETS TO EACH VISIT

Signature: _____ **Date:** 9/7/23