Injury Care Network, LLC

Provider WALLACE, D.O.
Patient ANGEL, THEODORE
DOB 09/15/1975 DOL 02/23/2023
DOS 08/11/2023

FOLLOW UP QUESTIONNAIRE

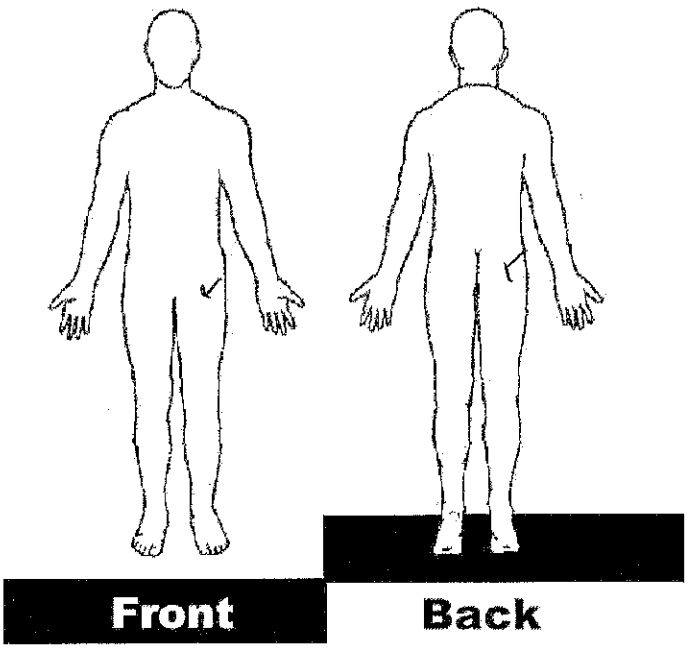
SINCE LAST VISI' , I AM FE LING:

- Same %
- ☐ Better 95 %
- ☐ 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)



PLEASE INDICATE ON THE DIAGRAM WHERE YOU ARE CURRENTLY HAVING PAIN

NEW CONCERNS: _____

SPECIFIC ISSUES YOU WOULD LIKE TO ADDRESS TODAY:

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

MEDICATION: None

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:** ___/___/____