Injury Care Network, LLC

Provider WALLACE, D.O.
Patient ANGEL, THEODORE
DOB 9/15/1975 DOL 2/23/2023
DOS 07/21/2023

FOLLOW UP QUESTIONNAIRE

SINCE LAST VISI , I AM FE LING:

- ☐ Same %
- ☐ Better ☑ %90
- ☐ Worse _ %
- ☐

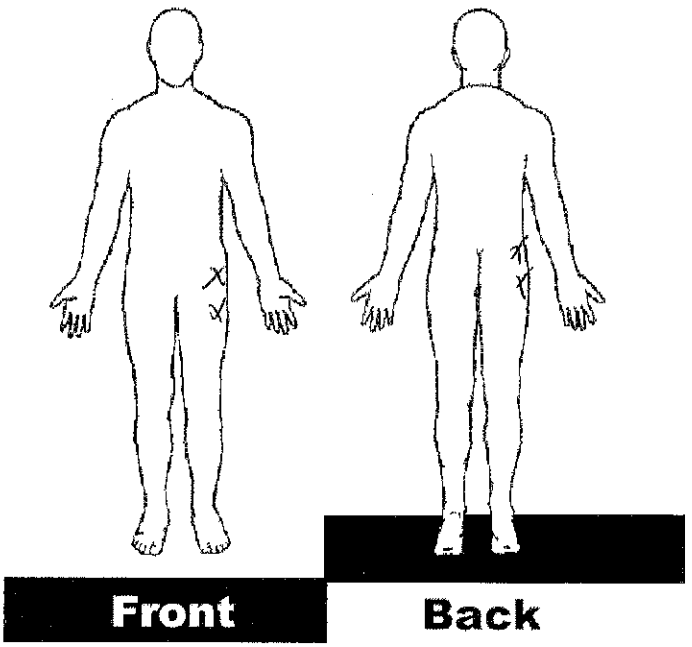
PLEASE RATE YOUR PAIN ON A SCALE OF ZERO TO TEN:

0-1-2-3-4-5-6-7-8-9-10

(NO PAIN) (SEVERE PAIN)

NEW CONCERNS: N/A

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:** 7/21/23