RETURNING PATIENT FORM

Patient Information

Pt. Last Name	First	Middle Init	Date of Birth	Age

Health Information

Reason for Visit	
Approximate date of condition onset	
Have any tests been done?	What was done?
Has any treatment been tried?	What was done?

Any CHANGES since your LAST appointment………

Has there been any change in your medications?	Yes	No	What changes?
Has there been any change in your medical condition?	Yes	No	What changes?
Has there been any hospitalizations?	Yes	No	Please explain:

Visual Analogue Scale Pain Assessment (Please circle the number that best answers the question)

What is your pain RIGHT NOW?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

What is your TYPICAL or AVERAGE pain?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain

Signature	**Date**

Payment of Benefits

I authorize the Release of any Medical Information to process my claim and request Payment of Benefits to the Physician. I understand that responsibility for payment for neurosurgical services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made.

Relationship to patient	**Date**
Signature	