Performance Rehabilitation

Patient Name: ____________________________________

Date: ________________ Time: _________________

Overall Percentage of Improvement (0-100%): ______________

(From 1st visit with Dr. Yadava)

Primary Care Physician First and Last Name and Phone Number:

____

Have you had any change of address, phone number, or insurance since your last visit? ________

Do you understand your condition? Yes No

Any medical changes or new injuries since your last visit? Yes No

Do you understand the purpose of your home program? Yes No

Can you demonstrate your home exercise program <u>completely</u>? Yes No

How well have you done with your home exercise program?

A	**B**	**C**	**D**	**F**
I have done exactly what I was told & then some.		I have done them 50% of the time.		I have not done them all.

Are you taking your medications as instructed? Yes No

Any changes to your current meds?_________________ **Are you working? Full time - Restricted Duty**

Status since last visit: Better Worse Same

Pain levels:

- Please place **2 circles** denoting your lowest and highest **pain range** over the last few days on the number line below.
- Then place an **' X '** on the **number line** over your **current** pain level.

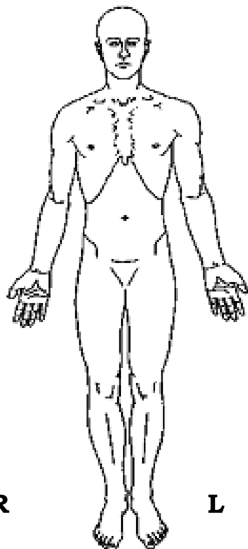
0 1 2 3 4 5 6 7 8 9 10

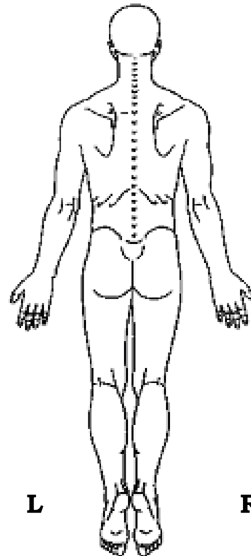
No pain Emergency Room

Describe any contributing factors to your pain status: ____

Do you have any questions for the doctor? If so, please provide a list to the receptionist.

Please denote your pain on the diagrams below utilizing the following symbols:

R  **L**

L  **R**

R **L**

<u>PAIN SYMBOLS</u>

/ / /	STABBING
XXX	BURNING
ooo	PINS & NEEDLES
===	NUMBNESS
+++	ACHING

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Patient's Signature for Dr. Yadava AND Hands On Therapeutics