ADVANCED
physical medicine
& therapy, ltd.
350 W. Kensington Rd. #102
Mt Prospect, IL 60056
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ReExam

Name_____ DOB_____

What was the chief complaint or reason you visited our office? (Low back pain, neck pain, etc.)

Complaint 1: _____
Pain Level: 0-10 (0= None; 10= Unbearable): Current ____ Average ____ Worst _____ Best _____

Complaint 2: _____
Pain Level: 0-10 (0= None; 10= Unbearable): Current ____ Average ____ Worst _____ Best _____

Complaint 3: _____
Pain Level: 0-10 (0= None; 10= Unbearable): Current ____ Average ____ Worst _____ Best _____

How do you classify your improvement so far since beginning your care? □Excellent □Good □Fair □Poor

What percentage of improvement do you perceive you have reached?
□0% □10 % □20% □30% □40% □50% □60% □70% □ 80% □90% □100%

What symptoms have improved? _____

Describe in detail the symptoms you still have: _____

Do you find it easier to: (Check all applicable) □Bend/Turn □ Lift □Stand □Sit □Sleep □Exercise □Complete house chores

Other_____

Is there any confusion or question about any phase of your care/progress?

_____

Is there any other condition you have that we have not discussed that you would like to discuss at this time? If yes,please explain: _____

Do you intend to follow the doctor's recommendations to avoid problems in the future? □Yes □No

Have you had an opportunity to refer a friend or family member to the doctor? □Yes □No □ Intend to do so

Are there any changes to your medication/ supplement list? □Yes □No If yes, please list on the reverse.

Your honest evaluation of the doctor's office is always appreciated. Please comment on ways we can improve our services. _____

Patient Signature_____ Date_____

Office Use ONLY Examiner Initials_____ C.A Initials_____

BP (mmHg) _____ Height _____ Weight (lbs)_____ Pulse: _____ O2Sat:_____ Temp_____