Patient Name_____
DOB_____

MINOR Patient Follow-up Questionnaire

What body part are you being seen for?

Has the pain improved since the last visit? **Yes** **No**
If yes, by what percentage has the pain improved? _____%

Are you currently participating in any physical activity? **Yes** **No**
If yes, which physical activities have you been able to participate in? Please list below (stationary bike, elliptical, specific sports, modified sports, etc.):

Which specific activities/movements aggravate your pain? Please describe below:

Are you currently participating in physical therapy? **Yes** **No**
If yes, at which facility? Which physical therapist (if known)?

Are you currently experiencing any numbness, tingling, or burning? **Yes** **No**
If yes, where do you experience the sensation? Which specific activities/movements elicit the sensation? Please describe below:

Are you using any medication? Please list below: