VISIT 3 and thereafter

Goal: Routine follow-up.

Ask your patient to limit follow-up office visits to one or two of the most bothersome symptoms.

Briefly inquire about the four cardinal symptoms:

- Pain
- Dyscognition
- Fatigue
- Sleep quality

Be sure to specifically comment on your patient's impairments and disability.

For ease and consistency, you may wish to use an Interim Questionnaire such as the one shown in **Chart 4** below.

RETURN OFFICE VISIT – INTERIM QUESTIONNAIRE

Name _____ Date _____

What are your three top symptoms or concerns today?

_____
_____
_____

Have you had any hospitalizations since last seen? [ ] No [ ] Yes (give details, including name of hospital):

_____

Have you had any major illness, injuries, or wrecks since last seen? [ ] No [ ] Yes (give details)

_____

Have you had any special medical studies (MRI, EEG, biopsies, endoscopies, etc.) since last seen? [ ] No

[ ] Yes: _____
_____

Have you seen any new doctors or providers since the last office visit?

[ ] Yes _____

Have you had an allergic reaction since last seen? [ ] No

[ ] Yes _____

Have you had any of the following routine studies since last seen (circle the ones you have had):

CBC	Blood chemistry	Thyroid	Diabetes check
ANA (lupus)	Lyme	Sed rate	Urinalysis
Other			

Indicate the severity of your symptoms by marking a carat (**V**) on the 10 point scales below:

Sleep	[___|___|___|___|___|___|___|___|___|___]	Poor Excellent
Fatigue	[___|___|___|___|___|___|___|___|___|___]	None Severe
Cognition problems	[___|___|___|___|___|___|___|___|___|___]	None Severe
Overall Body Pain (without pain meds)	[___|___|___|___|___|___|___|___|___|___]	None Severe
Overall Body Pain (with pain meds)	[___|___|___|___|___|___|___|___|___|___]	None Severe

The Activity Ratio

In an average day, please estimate how many hours you spend:

Asleep in bed ……. _____

Resting ……_____ [ ] Rest total
(sitting or lying quietly)
Doing light or sedentary activity … _____
(lift <20#, carry 10#, walk, stand, push/pull)
Doing moderate or heavy activity … _____ [ ] Activity total
(carry 10-25#, vacuum, rake, shopping)

TOTAL (must add to 24 hours) _____ [ ] Ratio (nl 0.5-1.0)

Functional Capacity

For how long can you sit still (e.g., watch TV)? _____

For how long can you stand in place (e.g., stand in line)? _____

For how long can you stroll or shop leisurely without resting? _____

Do you have difficulty working overhead? [ ] Yes [ ] No
Do you have difficulty manipulating small objects? [ ] Yes [ ] No
Do you have difficulty holding things? [ ] Yes [ ] No
Do you have difficulty kneeling? [ ] Yes [ ] No
Do you have difficulty bending or stooping (e.g. change bed)? [ ] Yes [ ] No
Do you have difficulty getting up from a chair? [ ] Yes [ ] No
Do you have difficulty getting up from the floor? [ ] Yes [ ] No
Do you have trouble getting out of a tub bath? [ ] Yes [ ] No

How much can you lift ? Put an X in the appropriate box, where

INFREQUENT means sporadically or uncommonly, up to occasionally
OCCASIONAL means 1 to 33% of an 8-hour work day
FREQUENT means in excess of 33% of an 8-hour work day

Weight or object	Not at all	Infrequently	Occasionally	Frequently	All day…
5 pounds					
A gallon jug					
10 pounds					
20 pounds					
25# of pet food					
More than 25 pounds					

Cognition

Check the cognitive problems that bother you:

[ ] Concentration (reading a book)
[ ] Comprehension (understanding what you just read)
[ ] Short term memory (forget recent conversations and events)
[ ] Long term memory (forget events in the distant past)
[ ] Calculation (mental math, making change, keeping a checkbook)
[ ] Verbal expression (searching for words, slips of the tongue)
[ ] Disorientation (temporarily lost in even familiar surroundings)
[ ] Confusion (can't remember how to do simple familiar tasks like run the computer, turn on the windshield wipers)

Exercise and Health-Enhancing Activities

Do you have a regular stretching or exercise program? [ ] Yes [ ] No

Describe it: _____

_____

_____

In what health-enhancing activities do you participate (circle or underline activities):

Massage	Acupuncture	Meditation	Ice / heat	Relaxation
Prayer	Visual imagery	Paraffin bath	Tai chi	Yoga
Quai gong	Chiropracty	Pool therapy	Spa / tub soaks	Massager (electric)
Others				