Terrapin Care Center
9658 Baltimore Ave, Ste 420
College Park, MD 20740-1423
301.220.1930
Fax: 301.220.1906

PATIENT SUBJECTIVE PROGRESS REPORT (*please complete BOTH sides*)

Name_____ Date of Birth:_____ Visit Date:_____
(Print Full Name)

In order for us to better serve you, we need this important confidential questionnaire answered completely by you. If you need any assistance, please do not hesitate to ask our staff for help. To comply with insurance policies, please write clearly and fill out ALL sections to the best of your ability. Thank you!

1. Please list your Conditions/Complaints today:

☐ Same as last visit: _____

☐ Different from last visit: _____

Frequency: ☐ **Constant** ☐ **On and off** ☐ **25%** ☐ **25-50%** ☐ **50-75%** ☐ **75-99% of the time**

2. Have you had any of the following **Since the Initial Visit**? (Please Check) ☐ **Yes** ☐ **No**

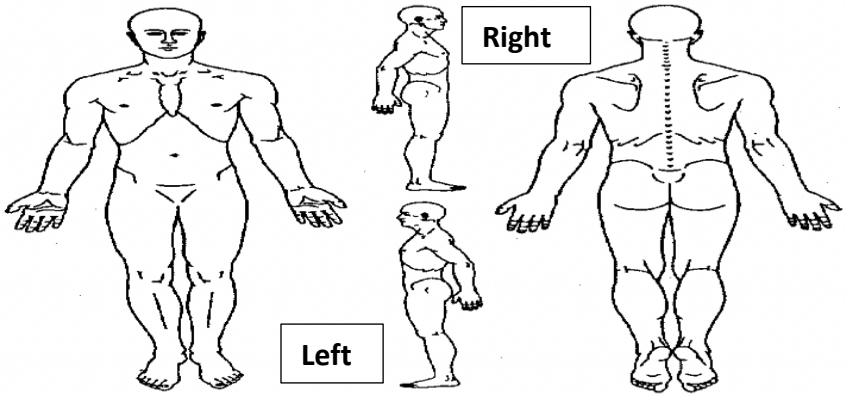
☐ **New problems** ☐ **Automobile Collision** ☐ **Work-related Injury** ☐ **Slip and Fall**

Please explain_____

If **Yes**, has this incident resulted in any increases in pain/symptoms since the last visit? ☐ **Yes** ☐ **No**
Describe:_____

3. **Describe your pain:** On the diagram below, mark the areas on your body where you feel pain along with pain intensity. Include all affected areas. Use appropriate symbol(s) listed below. If your pain travels/radiates, draw an arrow from where it starts to where it stops; please extend the arrow as far as the pain travels; Please indicate pain intensity: **"No pain" 0-1-2-3-4-5-6-7-8-9-10 "Severe"**

Ache	A A A A	**Numbness**	N N N N	**Pins and Needles**	P P P P	**Burning**	B B B B
Stabbing	X X X X	**Throbbing**	* * * *	**Tingling**	T T T T	**Sharp**	S S S S
Dull	D D D D	**Soreness**	⊕ ⊕ ⊕ ⊕	**Shooting**	→ → →	**Other**	O O O O



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PATIENT SUBJECTIVE PROGRESS REPORT *(Continued)*

4. How much time during an average day are you in pain/discomfort?
☐ Less than 1 hour per day ☐ Between 1 and 4 hours per day ☐ Between 4 and 8 hours per day
☐ Almost any time when not lying down. ☐ Almost 24 hours per day ☐
other_____

5. Please check the choice describing your response to the treatment **Since the Initial Visit**:
☐ My pain/condition is rapidly getting better.
☐ My pain/condition fluctuates, but overall is definitely getting better.
☐ My pain/condition seems to be getting better, but improvement is slow at present.
☐ My pain/condition is neither getting better nor worse.
☐ My pain/condition is gradually worsening.
☐ My pain/condition is rapidly worsening.

6. Does your condition affect your normal **Activities of Daily Living**, (i.e. dressing, bathing, grooming, standing, sitting, bending, stooping, walking, driving, shopping, cooking, etc.)? ☐ **Yes** ☐ **No**
If **Yes**, please check the severity/effect: ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Please explain/list activities:
_____

7. Does your condition affect you **Work**, (i.e., standing, lifting, typing, bending, sitting, carrying, walking, concentration, etc.)? (Please Check) ☐ **Yes** ☐ **No**
If **Yes,** please check the severity/effect: ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Please explain/list activities:_____

8. Does your condition affect your **Sleep**? (Please Check) ☐ **Yes** ☐ **No**
If **Yes,** please check the severity/effect: ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Please explain/list activities:_____

9. Does your condition affect your **Social and Recreational Activities**, (i.e. participating in individual or group activities, social life, sporting events, hobbies, etc.)? (Please Check) ☐ **Yes** ☐ **No**
If **Yes,** please check the severity/effect: ☐ **Mild** ☐ **Moderate** ☐ **Severe**
Please explain/list activities:_____

10. Who is filling out this questionnaire? ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature_____ Date _____