Follow-Up Form

Name: _____ **DOB:** _____ **Date:** _____

Where is your WORST pain? _____

Where else do you have pain? _____

Is your pain constant or intermittent? Constant Intermittent

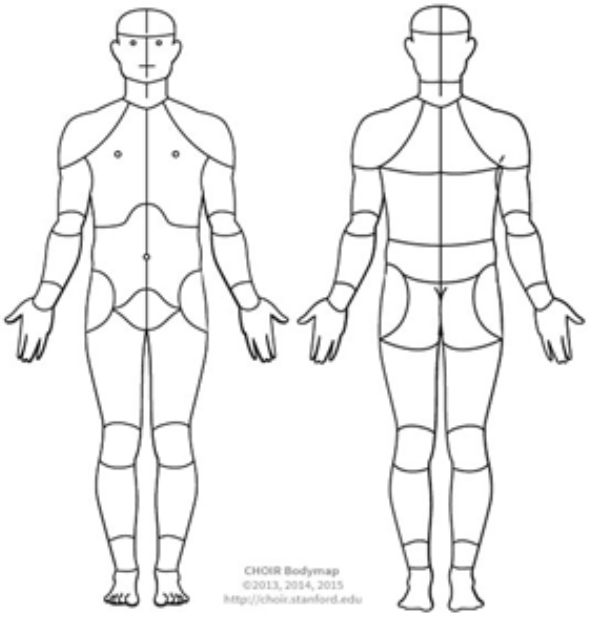
If intermittent, is there a time of day your pain is the worst? No ☐ AM ☐ Afternoon ☐ PM ☐

How would you describe your pain (circle all that apply)?

Aching ☐ Burning Cramping ☐ Numbness ☐ Pins/Needles ☐ Sharp ☐ Shooting ☐

Stabbing ☐ Tender ☐ Throbbing ☐ Tingling Weakness ☐ Other:_____

Shade the area(s) in the diagram where you currently have pain:



Has your pain changed since your last visit? Yes ☐ No ☐

What number best describes your <u>pain on average</u> in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

What number best describes how, during the past week, pain has interfered with your <u>enjoyment of life</u>?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

What number best describes how, during the past week, pain has interfered with your <u>general activity</u>?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

How good is your health <u>TODAY</u> (0 = worst health you can imagine; 100 = best health you can imagine)? _____

Indicate if you have any problems with any of the following tasks:

Walking? No ☐ Slight ☐ Moderate ☐ Severe ☐ Unable to walk ☐

Washing or dressing <u>yourself</u>? No ☐ Slight ☐ Moderate ☐ Severe ☐ Unable to wash/dress ☐

Usual activities (e.g. work, study, housework, family or leisure activities)?
No ☐ Slight ☐ Moderate ☐ Severe ☐ Unable to do usual activities ☐

Do you have any pain/discomfort? No ☐ Slight ☐ Moderate ☐ Severe pain ☐ Extreme pain/discomfort ☐

Do you feel anxious or depressed? No ☐ Slightly ☐ Moderately ☐ Severely ☐ Extremely ☐

Have you had trouble sleeping? No ☐ Yes ☐

What % relief do you get from your medications? SS _____

Do you have any medication side effects? No ☐ Yes: _____

Do you have any medication changes? No ☐ Yes: _____

Do you have any medical history changes? No ☐ Yes: _____

Please indicate if you are <u>CURRENTLY</u> experiencing any of the following:

General:	☐ Fever	☐ Chills	☐ Unexplained weight changes
Cardiovascular:	☐ Chest Pain	☐ Leg swelling	☐ Palpitations
Respiratory:	☐ Cough	☐ Shortness of breath	☐ Wheezing
GI:	☐ Constipation	☐ Diarrhea	☐ Dark or bloody stools
Musculoskeletal:	☐ Neck/Back Pain	☐ Arm/Leg Pain	☐ Joint Pain
Neurological:	☐ Headaches	☐ Loss of balance	☐ Numbness/Tingling
Psychiatric:	☐ Anxiousness	☐ Depressed mood	☐ Suicidal or homicidal thoughts