Spine Pain Centers

FOLLOW UP QUESTIONNAIRE

***Office use only*
Provider _____ Appt time _____
___ entered ___ vitals

Patient Name _____ **DOB** _____ **Date** _____

Referring Provider: _____ **PCP:** _____

Allergies (include allergies/side effects to medications or seafood): _____

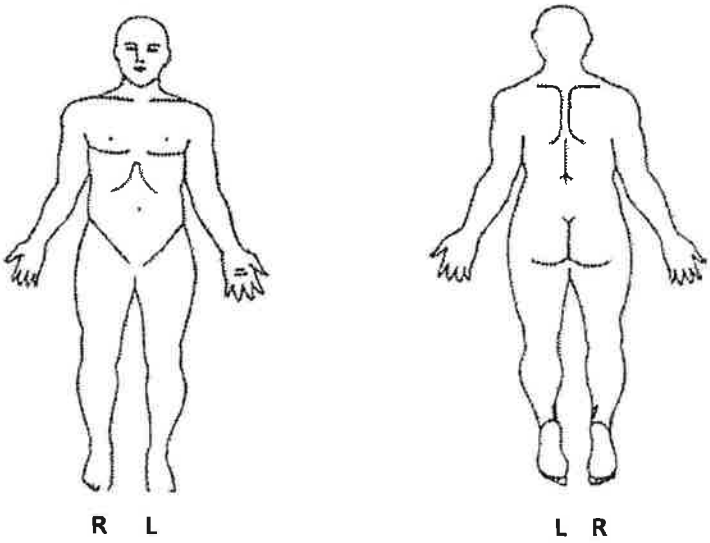
List any CHANGES to your current medications since your last visit: See attached medication list

This visit is related to a: ☐ Workers' Compensation injury ☐ Motor Vehicle Accident

Other items you would like to discuss ☐medications/rx refills ☐imaging ☐work status

Chief Complaint _____

On the diagram, shade in the areas where you feel pain?



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Indicate Current Pharmacy if changed since last visit

Name: _____

Address: _____

Phone: _____

Do your medications help? ☐Yes ☐No **Name of medications:** _____

If applicable, did your last procedure help? ☐Yes ☐No **Name of procedure:** _____

Has your level of activity improved since your last visit? ☐yes ☐no ☐stayed the same

Please identify your pain level today:

Pain level today 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = unbearable pain)

Over the last 2 weeks, please identify your pain levels below: (0 = no pain 10 = unbearable pain)

Severe pain level 0 1 2 3 4 5 6 7 8 9 10

Average pain level 0 1 2 3 4 5 6 7 8 9 10

Describe your pain ☐throbbing ☐dull ☐aching ☐shooting ☐stabbing ☐burning ☐tingling ☐pins/needles

Do you experience: ☐numbness ☐weakness ☐fevers/chills ☐swelling

Please continue to the back of the form /page 2 →

NATIONAL Spine & Pain CENTERS

FOLLOW UP QUESTIONNAIRE

What activities increase your symptoms:

☐sitting
☐standing
☐walking
☐bending forward
☐bending backward
☐lifting
☐lying flat
☐bending to the right
☐bending to the left
☐driving
☐cold/damp weather
☐coughing/sneezing

Medications tried:

☐Oral NSAIDS (Ibuprofen/prescription strength Motrin)
☐Over the counter agents (Tylenol/Aspirin)
☐Muscle relaxants (Flexeril/Skelaxin)
☐Prescription pain medications (Vicodin/Dilaudid)
☐Prescription nerve medications (Lyrica/Cymbalta)
☐Prescription topical agents (Voltaren gel/Lidoderm patch)

What activities decrease your symptoms:

☐nothing
☐sitting
☐standing
☐walking
☐rest
☐ pain medication
☐avoiding strenuous activity
☐lying with pillow between legs
☐heat
☐ice application
☐stretching
☐massage
☐chiropractic manipulation
☐acupuncture
☐swimming

Previous conservative measures

☐physical therapy
☐chiropractic treatment
☐exercises
☐bracing
☐massage
☐acupuncture
☐NSAIDs
☐nerve pain medications
☐opiates

Are there any changes to your Past Medical, Past Surgical, or Social histories? ☐yes ☐no
If yes, please list _____

FAMILY HISTORY: ☐None ☐Unknown

Please list all medical conditions that are common in your family:

☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other:_____ _____
☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other:_____ _____
☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other:_____ _____
☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other:_____ _____

Tobacco use: ☐Yes ☐No Former smoker: ☐Yes ☐No

REVIEW OF SYSTEMS - PROBLEMS EXPERIENCING AT THE PRESENT TIME:

☐Fever	☐Dry Eye	☐Dry Mouth	☐Leg Swelling	☐Shortness of Breath	
☐Constipation	☐Involuntary Urine Loss	☐Poor Balance	☐Dry Skin	☐Joint Swelling	
☐Sleep Disturbance	☐Depression	☐Anxiety	☐ Weight Loss	☐Easy Bleeding	☐Rash

The above information is accurate to the best of my knowledge:

Patient Signature: _____ Date: _____