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): _____

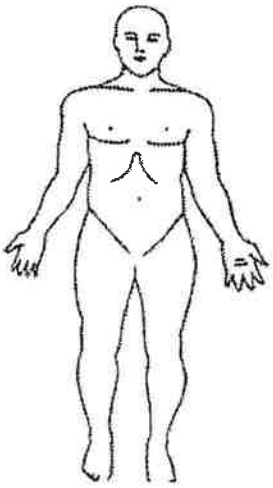
List any CHANGES to your current medications since your last visit: See attached medication list

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

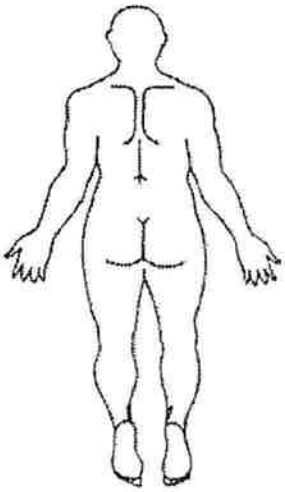
Other items you would like to discuss ☐medications/rx refills ☐imaging ☐work status

Chief Complaint _____

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



R L



L R

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

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

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

_____
_____
_____
_____

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: _____

NATIONAL Spine & Pain CENTERS

Patient Name _____ **Patient ID** _____

DOB _____ **Date**_____

NSPC is dedicated to providing comprehensive care to patients and following the federal guidelines regarding important public health issues. *Please circle your answer to the following questions.*

SECTION 1: DEPRESSION

Over the last 2 weeks, how often have you been bothered by the following problems?

Are you currently being treated for a diagnosis of depression?	YES	NO

If you answered Yes to the above question please DO NOT COMPLETE the remainder for Section 1

	Not At All	Several days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

SECTION 2: ADVANCED DIRECTIVE

Are you age 65 or older?	YES	NO

In the event that you are incapacitated, who would you like to have make your medical decisions? *Provide name, phone number, and relationship. If none assigned, leave blank.*

_____

SECTION 3: FALL RISK

Please circle "Not Applicable" if you Use Wheelchair for Mobility or are Unable to Walk

Do you feel unsteady when walking? YES NO NOT APPLICABLE (N/A)

Do you worry about falling? YES NO NOT APPLICABLE (N/A)

Have you fallen in the past 1 year? YES NO

If yes, how many falls? 1 2 3 or more falls

Were you injured during any of the falls? YES NO

SECTION 4: TOBACCO USE

Are you currently smoking cigarettes or using other tobacco products? YES NO

SECTION 5: BLOOD PRESSURE

Have you ever been diagnosed with high blood pressure (Hypertension)? YES NO

Patient Signature: _____ Date_____

NATIONAL Spine & Pain CENTERS

Patient Name _____ **Patient ID** _____

DOB _____ **Date** _____

SECTION 5: HYPERTENSION (continued from page 1)

BP: Systolic _____ / Diastolic _____

SECTION 6: BODY MASS INDEX

What is your height? _____feet _____inches What is your weight? _____lbs.

Official Use Only **BMI =**

SECTION 7: Medication Documentation

Official Use Only *See Medication List is Patient Chart.*

SECTION 8: Pain Assessment

Official Use Only *See pain scale in office note*

Completed by staff member: _____