Follow-up Pain Assessment Questionnaire

DATE: ______________________

NAME: ______________________

Last     First     Middle

Male    Female   (circle)    AGE: ______________________     DOB: ______________________

Where is your pain? __________________________________________________________

Please check the words that best describe your pain.
- Aching
- Dull
- Constant
- Numbing
- Coldness
- Burning
- Sharp
- Stinging
- Stabbing
- Tingling
- Cramping
- Radiating

Please shade the area(s) of your pain.

Since your LAST office visit, have you had any pain management injections (interventional procedures)?    □ Yes    □ No

If yes, injection type, and date: _______________________________________________________

Did you have any pain relief from the injection(s)?    □ Yes    □ No

If yes, how much pain relief did you receive?
- 10%
- 20%
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%

Since your LAST office visit, have there been any changes in your pain medication regimen, or any new pain medications prescribed, either by your PVPS physician or by any other doctor(s)?    □ Yes    □ No

If yes, please list medication, dose, directions, and physician prescribing: ____________________________________________

Since your LAST office visit, have there been any changes in your medical condition, any new symptoms or diagnoses, or any changes in your family or living conditions?    □ Yes    □ No

If yes, please explain: _______________________________________________________

_____________________________________________________________________________
Pain Scales
(0 = No pain  10= Worst pain)

Please rate your present pain level.

0 1 2 3 4 5 6 7 8 9 10

Please rate your worst pain level.

0 1 2 3 4 5 6 7 8 9 10

Please rate your average pain level.

0 1 2 3 4 5 6 7 8 9 10

Sleep Behavior Update
Your ability to sleep since your last office visit is:  
- Improved
- Worsened
- Remained the same

Employment Status Update
How has your employment status changed since your last visit?

Treatment Update
Since your last office visit, have you been hospitalized or had surgery for any reason?  
- Yes
- No

If yes, please explain.

Have you been seen by any other physician?  
- Yes
- No

If yes, who and for what reason:

Current pain treatments include:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>No Relief</th>
<th>Moderate Relief</th>
<th>Excellent Relief</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care</td>
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<td>Home Exercise Program</td>
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<td>Physical Therapy</td>
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<td>TENS Unit</td>
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<tr>
<td>Traction</td>
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<tr>
<td>Orthotics/Bracing</td>
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<tr>
<td>Other: __________</td>
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</tbody>
</table>

Do your pain medications provide pain relief?  
- Yes
- No
- I do not take pain medications

If yes, how much pain relief do you receive?

- 10%
- 20%
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%
Do your pain medications improve your function?  □ Yes  □ No  □ I do not take pain medications
   If yes, how much improvement in function do you receive?
   □ 10%  □ 20%  □ 30%  □ 40%  □ 50%  □ 60%  □ 70%  □ 80%  □ 90%  □ 100%

Please indicate any side effects caused by your pain medications.
   □ Nausea  □ Vomiting  □ Rash  □ Constipation  □ Upset Stomach  □ Sedation
   □ Dizziness  □ Acid Reflux  □ Itching  □ No side effects  □ Other: ________________________

Current Medications

□ Please check off this box if you have reviewed the last dictation and your medications are unchanged.
If your medications have changed, please list all medications that are currently prescribed to you:

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Directions</th>
<th>Prescribing Doctor</th>
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</table>

Review of Systems

Are you currently experiencing any of the following?

<table>
<thead>
<tr>
<th>General</th>
<th>Neuro</th>
<th>Eyes</th>
<th>Respiratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>□ □ Chills</td>
<td>□ □ Headaches</td>
<td>□ □ Visual changes</td>
<td>□ □ Shortness of breath</td>
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<td>□ □ Night sweats</td>
<td>□ □ Dizziness</td>
<td>□ □ Persistent cough</td>
<td>□ □ Difficulty breathing</td>
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<tr>
<td>□ □ Fever</td>
<td>□ □ Weakness (specify)</td>
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<tr>
<td>Cardiovascular</td>
<td>Gastrointestinal</td>
<td>Skin</td>
<td>Genitourinary</td>
</tr>
<tr>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>□ □ Chest pains</td>
<td>□ □ Nausea</td>
<td>□ □ Sores</td>
<td>□ □ Urinary retention</td>
</tr>
<tr>
<td>□ □ Abnormal heart beat</td>
<td>□ □ Vomiting</td>
<td>□ □ Rashes</td>
<td>□ □ Urinary incontinence</td>
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<tr>
<td></td>
<td>□ □ Diarrhea</td>
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<td>□ □ Urinary discharge</td>
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<td></td>
<td>□ □ Bowel incontinence</td>
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<tr>
<td></td>
<td>□ □ Constipation</td>
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By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also understand that I may receive a copy for my records.

Signature of Patient / Guardian / or Patient Representative

Date

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