NAME_____

# Pain Follow-Up

| Medication/Supplement | Dose | Frequency | Does It Help? Yes/No/Not Sure | Any Side Effects? |
|---|---|---|---|---|
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PAIN ASSESSMENT:

Briefly describe how you have been doing since your last visit:

_____

_____

_____

_____

RATE YOUR PAIN: On a scale of 0 to 10; where 0 is no pain and 10 is the worst pain you can imagine:

This Month:

Average: _____ Best: _____ Worst: _____

Do medications make a difference? ◯ Yes ◯ No If yes, % of Relief: _____%

DESCRIBE YOUR PAIN:

Where is your pain? _____

What does it feel like (sharp, burning, pressure, stabbing, achy, etc.)?_____

_____

Is your pain constant or does it come and go? _____

_____

How often during the day are you inactive because of pain?

___Constantly (80-100% of the time) ____Most of the time (50-80% of the time)

___Significantly (30-50% of the time) ____Occasionally (less than 30% of the time)

Are you smoking? ◯ No ◯ Yes If yes, how may cigarettes per day? _____/day.

NAME_____

**DAILY LIVING FUNCTIONS: (Mark an "X" whether "Better", "Same" or "Worse")**

| | Better | Same | Worse | What have you noticed? |
|---|---|---|---|---|
| Physical Functioning | | | | |
| Family Relationships | | | | |
| Social Relationships | | | | |
| Mood | | | | |
| Sleep Patterns | | | | |
| Overall Functioning | | | | |

Please circle if you are experiencing any of the following since your last visit:

Weakness (Where?)_____ Numbness (Where?) _____

Constipation Diarrhea Visual Changes Confusion Forgetfulness

Bouts of Depression Lightheadedness Decreased Balanced Excessive Sweating Dry Mouth

Bouts of Anxiety Bladder Accidents Bladder Retention Ringing in the Ears Weight Gain

Excessive Hair Loss/Growth Increased Fatigue/Drowsiness Sexual Dysfunction

Decreased Libido Weight Loss Black Outs/Falls Psychological Changes

Excessive Itching Rashes/Skin/Nail Changes Other_____

PHYSICAL THERAPY:

PT evaluation completed? Yes/No Is therapy beneficial to you? Yes/No

Currently in therapy? Yes/No Home exercise program? Yes/No

What exercises are you doing? _____

_____

PAIN PSYCHOLOGY:

Initial Evaluation completed? ___Yes ___No

Are you following up with the psychologist and/or psychiatrist if recommended? ☐ Yes ☐ No ☐ N/A

Is therapy beneficial to you? ___Yes ___No

Any new problems or pain since your last visit? ___Yes ___No If "No", please skip to the bottom, sign, and date.

_____

_____

Patient Signature_____ Date: _____