NAME______________________

Pain Follow-Up

Medication/Supplement	Dose	Frequency	Does It Help? Yes/No/Not Sure	Any Side Effects?

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)

What percentage improvement have you experienced since your last visit?_____%

Any changes in your medical treatment (Including tests, new doctors, hospitalizations, etc…)______________

____

____

NAME____________________

Are you smoking? ___ No ____Yes If yes, how may cigarettes per day? ___________/day.

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.

____

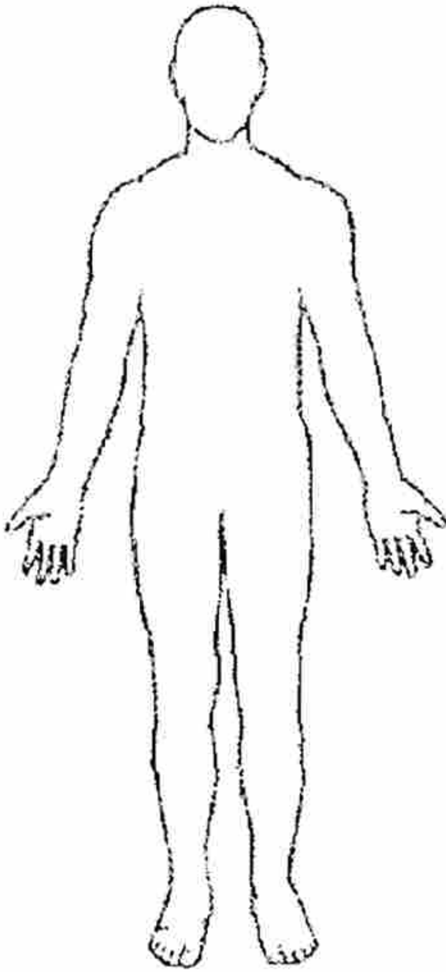
____

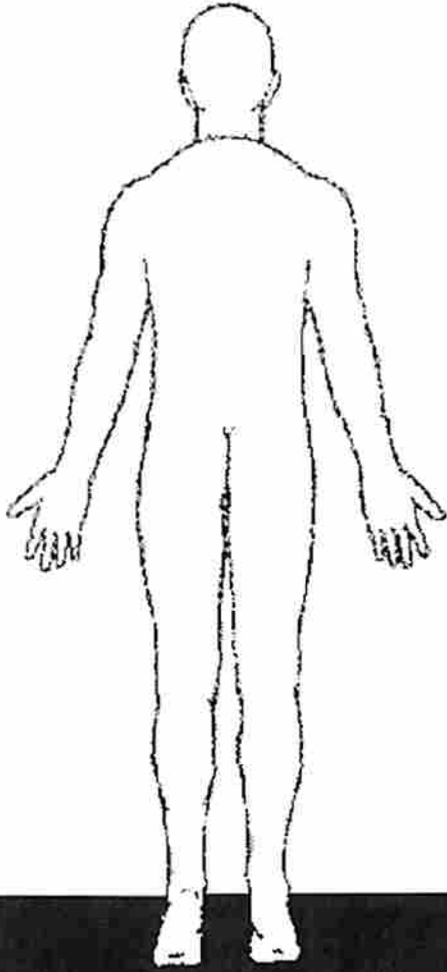
Patient Signature____ Date: ______________

NAME_______________________

Mark the areas on your body where you feel the described sensations, areas of radiation, including all affected areas. Please use the appropriate symbol.

Numbness--------	Burning xxxxxxxx	Stabbing ////////	Hot HHHHH	Cold CCCC
Tingling >>>>>	Sharp Pain +++++	Dull Ache \\\\\\	Pins/Needles 0000	





Front

Back