Today's Date: ____________________

Name: ____________________

DOB: ____________________

Weight: ____________________

Height: ____________________

FOLLOW UP VISIT

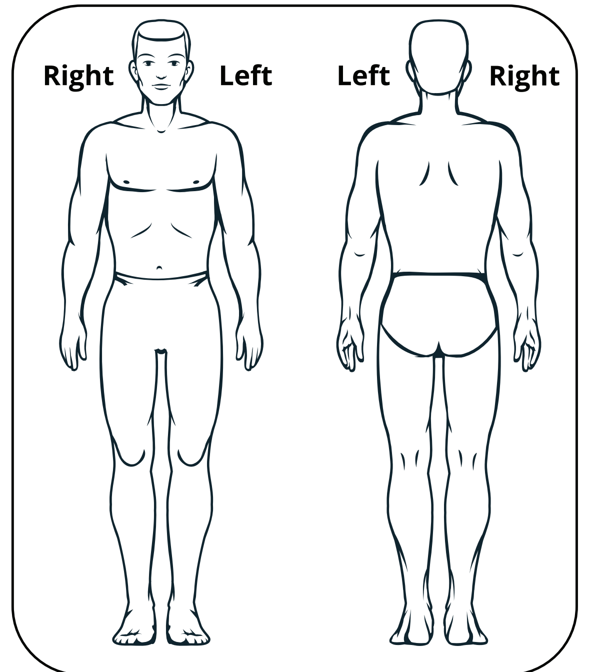
Please carefully complete all sections of this form, even if nothing has changed since your last visit

Reason for Today's Visit

☐ Post-Procedure
☐ Review Test Results
☐ Assessment Review MRI Results
☐ Other: ____________________

Pain Description

Use the diagram to indicate the location of your pain



What number on the pain scale (1-10) best describes your worst pain over the last week? ____________________

Where is your worst area of pain located? ____________________

____

Does this pain radiate? If so where? ____________________

____

Changes Since Your Last Visit

Have you developed any new pain complaints since your last visit that you would like to discuss today?

☐ Yes ☐ No

If yes please Explain: ____________________

Since your last appointment, how has your pain changed?

☐ Decreased ☐ Increased ☐ Stayed the Same

If you had a procedure, how much pain relief did you obtain?

☐ None ☐ 10% ☐ 20% ☐ 30% ☐ 40%
☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Any problems since procedure? ☐ Yes ☐ No

If yes please explain: ____________________

Check all that describe your pain today:

☐ Dull ☐ Electric ☐ Shooting
☐ Hot/Burning ☐ Numbness ☐ Cramping
☐ Stabbing/Sharp ☐ Deep ☐ Throbbing

What word best describes the frequency of your pain?

☐ Constant ☐ Intermittent

When is your pain at its worst?

☐ Mornings ☐ During the day
☐ Evenings ☐ Middle of the night
☐ Worse on Activity ☐ Worse at rest

What makes your pain better? ____________________

What makes your pain worse? ____________________

MARK ALL OF THE FOLLOWING ACTIVITIES THAT ARE ADVERSELY/NEGATIVELY AFFECTED BY YOUR PAIN:

☐ Enjoyment of life ☐ Normal Work ☐ General Activity ☐ Recreational Activities
☐ Walking ☐ Mood ☐ Relationships with People ☐ Other:______________

SINCE YOUR LAST VISIT, HAVE YOU DEVELOPED ANY NEW:

☐ Bladder Incontinence (not including frequency) ☐ Bowel Incontinence (not including diarrhea or constipation)
☐ Balance Problems ☐ Fevers ☐ Chills ☐ Difficulty Walking ☐ Nausea ☐ Vomiting

Numbness/Tingling-Where? _______________________ Weakness-Where? _______________________

☐ I HAVE NOT DEVELOPED ANY RECENT PROBLEMS WITH ANY OF THE ABOVE CONDITIONS SINCE MY LAST VISIT.

Are you currently taking any blood-thinners or anticoagulants? Including Aspirin or Fish Oil?

☐ Yes ☐ No

Do you take any of these Blood Thinners? (Mark all that apply)

☐ Aspirin ☐ Fish Oil ☐ Aggrenox ☐ Coumadin/Warfarin
☐ Effient/Prasugrel ☐ Lovenox/Enoxaparin ☐ Plavix/Clopidogrel ☐ Pletal/Cilostazol
☐ Pradaxa/Dabigatran ☐ Ticlid /Ticlopidine ☐ Brilinta/Ticagrelor ☐ Xarelto/Rivaroxaban
☐ Eliquis/Apixaban ☐ Heparin/Subcutaneous ☐ Arixtra/Fondaparinux ☐ Edoxaban/Savaysa
☐ Other: __________________________

Patient Signature: _____________________________________ **Date:** ____________________________