PRINCIPAL SPINE AND PAIN CONSULTANTS
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FOLLOW UP FORMS

Patient's name (Print): _____ D.O.B _____ Date: _____

Sudo Scan: YES / NO ********** (Office use only) Pharmacy Confirmed: Yes / No

Vitals: BP: _____ HR: _____ Temp: _____ Weight: _____

Urine Drug Screen Done: YES NO SOAP Note Done: YES / NO

FOLLOW UP QUESTIONNAIRE. Please answer all questions. Please Print all answers and write neatly.

Where is your pain located?

How severe is your pain?
(0 is no pain, 10 is worst pain) *Right now:* _____ *Average:* _____

How often do you have pain? Constantly Intermittently Infrequently

What is the pain like?

Achy	*Sore*	*Cramping*	*Dull*	*Throbbing*
Numb	*Stabbing*	*Pressure*	*Sharp*	*Shooting*
Pins/needles	*Hot/burning*	*Tingling*	*Other* _____	

Does your pain radiate or shoot to another location? NO

Left Hand	*Right Hand*	*Trunk*	*Other* _____
Left Arm	*Right arm*	*Flank*	
Left Leg	*Right leg*	*Groin*	

What makes your pain worse? NOTHING

Bending *Lifting* *Sitting* *Standing* *Activity* *Walking*
Other _____

What makes your pain better? NOTHING

Medications	*Heat*	*Walking*	*Other:* _____
Injections	*Cold*	*Sitting*	
Rest		*Standing*	

Are you having any of these associated symptoms? NONE

Muscle Cramp/spasms	*Numbness*	*Loss of bowel/bladder control*
Weakness	*Poor Sleep*	*Feeling sad*

What is your goal for pain control? _____

Do you feel your condition is: *Improved* *Well-controlled*
Inadequately controlled *Worsening* *Unchanged*

Do you exercise and stretch? Never Occasionally Weekly 2-3 times a week Daily

Did you have a procedure at your last visit? YES NO

What procedure did you have? _____

What was your pain score before the procedure (0-10)? _____

What was your pain score immediately after? _____

How long did the pain relief last for? _____

Did you like the results of the procedure? YES NO

Any problems from the procedure? Redness Bleeding Bruising Weakness Numbness
Increased pain at injection site Other: _____

Would you go through the procedure again? YES NO

List the medications we are prescribing to you:

NAME OF MEDICATION	DOSE	Is it helpful?
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO

How much pain relief are you getting from the medications? _____ (10%, 50% etc)

Are you seeing any improvements in your daily activities? YES NO

Are you having any of the following side effects?

Sleepiness *Disorientation* *Nausea* *GI Upset* *Rash* *Swelling* *Constipation*

Other _____

What has helped most with your pain? _____

Are you satisfied with your current level of pain control? YES NO

Please list any new allergies to medicines: _____

Any new medical conditions, medications, or surgeries?

**** SYMPTOMS REVIEW (Do you have any of these?)*

Constitutional:	fever	weight gain	weight loss	
Ears:	dizziness	earaches		
Head/Neck/Eyes:	visual changes	headaches	neck pain	
Nose/Throat:	hoarseness	swallowing difficulty		
Cardiovascular:	chest pain	leg swelling	poor circulation	irregular heart beat
Respiratory:	coughing	asthma		
Gastrointestinal:	heartburn	nausea/vomiting	stomach ulcer	constipation
Musculoskeletal:	muscle cramps stiffness	arthritis cold-weather pain	swollen joints	
Skin:	rash	itching		
Neurological:	weakness	numbness	poor coordination	
Psychiatric:	depression	anxiety	mood swings	
Hematologic:	easy bruising	anemia		
Endocrine:	excessive urination	heat/cold intolerance		
Urinary:	painful urination	loss bladder control	blood in urine	
Men only:	prostate trouble	erectile dysfunction		
Women only:	irregular periods	menstrual cramps		

Do you feel a back brace would help with your pain? YES NO Physical Therapy? YES NO Tens unit? YES NO

If you are using any of these items is it helping your pain and what are you using? _____

is there anything else you would like to discuss? _____