Follow Up

Date of visit: _____

Name: _____

Date of birth: _____

Pain Description

Where is the location of your worst pain today?

_____

Is this pain new? □Yes □ No

Since your last office visit, has the pain

□ Stayed the same □ Increased □ Decreased

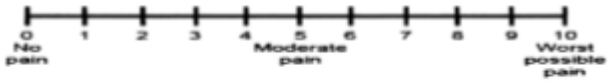
How would you describe your pain?

□Sharp □Dull □Aching □Burning □Shooting
□Stabbing □Throbbing □ Other:_____

Is Your Pain □ constant □ Intermittent

How often do you have flare-ups of pain?
□Daily □ every 2-3 days □ every 4-5 days

PAIN SCALE Over the last month, rate your pain 1-10:
Currently: ____ **Worst:** _____ **Least Level:** ____
With Medication _____



Office Use Only:
Ht: _____ Wt: _____Temp: _____O2: _____
BP: _____ / _____ Pulse: _____
Risk level: Low Mod High
SOAPP-R Score: _____ PHQ-9: _____
Drug Screen: UDS POC/Oral Swab
□ Not Required □ Done
Patient last took pain medication: _____
Previous UDS: Consistent Inconsistent
BZO BAR COC THC MET OPI/MOP MTD TCA OXY PCP AMP BUP NEGATIVE

Does the pain radiate? Where?

_____

Do you feel any:

□ Tingling Where: _____
□ Numbness Where: _____
□ Weakness Where: _____

Pain is worse with: (Mark all that apply)

□ Standing □ Walking □ Exercise □ Sitting
□ Bending □ Lifting □Driving
□Using the Computer

Did you have a procedure for your pain? □Yes □ No
If Yes, did it help? □ Yes □ No Please explain:

_____

Percent of improvement in pain (0-100%) _____

Any problems with the procedure?

_____

Are you getting relief from pain with your current medications? □Yes □No

Percent of improvement in pain (0-100%) _____

Mark medication side effects, if any:

□ Drowsiness □ Itching □ Dry mouth
□ Nausea □ Constipation □ No side effect

Are you able to perform the following tasks with medication: □ Activity of Daily Living □ Walking
□ Exercise □ Sleep □ Working

Does your pain interfere with your:

□ Walking □ Work □ Hobbies □ Sleep
□ Housework □ Activity of Daily Living