Followup Visit Form

1. Followup Visit Form

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

Name

Date of Birth

Has your medical coverage/insurance changed since your last visit?
○ No ○ Yes

Reason for Today's Visit
☐ Medication Refill ☐ Medication Change ☐ Post-Procedure Follow-up ☐ MRI/X-Ray Follow-up
☐ Test Results ☐ Other

If you specified OTHER above, please explain

Please indicate any AGGRAVATING factors to your pain.
☐ Bending ☐ Sitting ☐ Standing ☐ Laying down ☐ Twisting ☐ Walking ☐ Coughing ☐ Running

Please indicate any ALLEVIATING factors to your pain.
☐ Resting ☐ Meds ☐ Standing ☐ Laying Down ☐ Stretching ☐ Walking ☐ Chiro ☐ TENS
☐ Accupuncture

When is your pain at its worst?
☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

Please check all of the following activities that are adversely/negatively affected because of your pain.
☐ General Activity ☐ Mood ☐ Normal Work ☐ Relationships with People ☐ Enjoyment of Life
☐ Walking ☐ Sleep ☐ Recreational Activities ☐ Other

If you indicated OTHER above, please explain.

2. If you recently had an injection, please complete the section below.

Injection

Date of Injection

How much relief did you experience?
○ None ○ 10% ○ 20% ○ 30% ○ 40% ○ 50% ○ 60% ○ 70% ○ 80% ○ 90% ○ 100%

How long did the relief last?

Is the relief still lasting?
○ ○

3. If you have any future injections, please indicate below.

	Future injection	Date

4. Please indicate your current level of pain right now.

- ○ 0 - No Pain
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 - Unbearable Pain

5. Please indicate the WORST level of pain you've experienced recently

- ○ 0 - No Pain
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 - Unbearable Pain

6. Please indicate the LEAST level of pain you've experienced recently

- ○ 0 - No Pain
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8
- ○ 9
- ○ 10 - Unbearable Pain

7. Please indicate the AVERAGE level of pain you've experienced recently

8. Where is your worst area of pain located?

____

9. Does this pain radiate? If so, where?

____

10. Please check all that describe your pain today.

- ☐ Aching
- ☐ Shooting
- ☐ Tingling/Pins & Needles
- ☐ Shock-like
- ☐ Throbbing
- ☐ Stabbing/Sharp
- ☐ Cramping
- ☐ Spasming
- ☐ Tiring/Exhausting
- ☐ Dull
- ☐ Squeezing

11. What word would best describe the frequency of your pain?

- ○ Constant
- ○ Intermittant
- ○ Random

12. **Please indicate any AGGRAVATING factors to your pain.**

- ☐ Bending
- ☐ Sitting
- ☐ Standing
- ☐ Laying down
- ☐ Twisting
- ☐ Walking
- ☐ Coughing
- ☐ Running

13. Have you developed any new pain complaints since your last visit you would like to discuss today?
○ No ○ Yes

If you answered YES to the question above, please explain.

____

Since your last appointment, has your pain...
○ Increased? ○ Decreased? ○ Stayed the same?

Since your last visit, have you developed any of the following?
☐ Balance Problems ☐ Difficulty Walking ☐ Bladder Incontinence ☐ Bowel Incontinence ☐ Nausea
☐ Weakness ☐ Chills/Fever ☐ Vomiting ☐ None of the above

Have you tried physical therapy?
○ No ○ Yes

If yes, for how long?
____

Approximately when did the physical therapy occur?
____

How much pain relief did physical therapy provide?
○ None ○ 10% ○ 20% ○ 30% ○ 40% ○ 50% ○ 60% ○ 70% ○ 80% ○ 90% ○ 100%

How long did the relief last?
____

Is the relief still lasting?
○ No ○ Yes

14. **Do you need any medication refills today?**

○ No
○ Yes

15. **Please list the medications needing refills.**

	Medication Name	Dosage	Change

16. **Are you currently taking any blood-thinners or anticoagulants?**

○ No
○ Yes

17. **Please mark the following medication side-effects you are experiencing if any.**

- ☐ Confusion
- ☐ Constipation
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Dry Mouth
- ☐ Nausea
- ☐ I am stable on my current medications
- ☐ Vomiting
- ☐ Weight Gain
- ☐ My medications help to improve my functioning and quality of life

Please sign or print your full name.

Signature Date