INNOVATIVE PAIN AND WELLNESS
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Follow-Up Paperwork

****Please fill out this paperwork in its entirety. DO NOT use "same" for any answers.****

Today's Date:_____ Today's Provider:_____

Your Name:_____ Date of Birth:_____

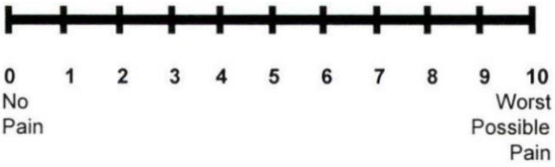
Height:_____ Weight:_____

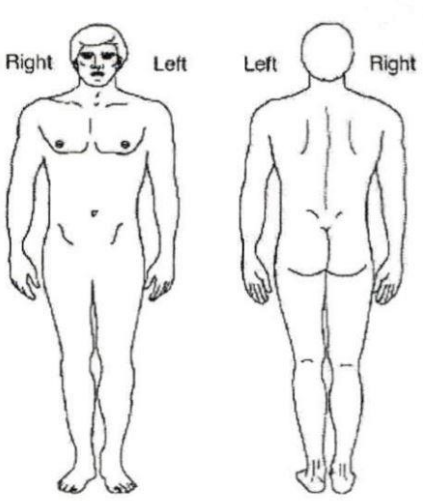
Reason For Today's Visit

□ Medication Refill □ Medication Change □ Post-Procedure Assessment

□ Review Test/Imaging Results □ Other:_____

Pain Description





Please rate your pain using a 0 – 10 scale:
_____ Your **pain right now**?
_____Your **worst pain**?
_____Your **least pain**?
_____Your **average pain over the last month**?

Where is your worst area of pain located?
_____

Does this pain radiate? If so, where?
_____

Check all that describe your pain today:

□ Aching □ Spasming
□ Cramping □ Squeezing
□ Dull □ Stabbing/Sharp
□ Hot/Burning □ Throbbing
□ Numb □ Tingling/Pins & Needles
□ Shock-like □ Tiring/Exhausting
□ Shooting

Pain Frequency

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

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Mark all of the following activities that are adversely/negatively affected by your pain

□ Enjoyment of Life □ Normal Work □ Sleep

□ General Activity □ Recreational Activities □ Walking

□ Mood □ Relationship with people □ Other:_____

Since your last visit, have you developed any new:

□ Balance Problems □ Bladder Incontinence □ Bowel Incontinence □ Chills

□ Difficulty Walking □ Fevers □ Nausea □ Vomiting

□ Numbness/Tingling – Location:_____

□ I have not recently developed any of the above conditions.

Changes since your last visit

□ I have not had any changes since the last office visit

Have you developed any new pain complaints? □ Yes □ No If yes, where?_____

How has your pain changed? □ Increased □ Decreased □ Same

What additional treatments have you done?

□ Procedure If so, what procedure(s)?_____

□ Physical Therapy How many treatments?_____

□ Chiropractic How many treatments?_____

□ Medication Which medication(s)?_____

How much relief have you obtained? _____% Which treatment(s)?_____

Current Medications

Please list any changes since your last visit in the medications you are currently taking.

Medication: **Dosage:** **Date:**

_____

_____

_____

Are you taking any blood-thinners or anticoagulants? □ Yes □ No

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Review of Symptoms

Mark the following symptoms that you currently suffer from.

Constitutional:

□ Chills □ Difficulty Sleeping □ Easy Bruising
□ Excessive Sweating □ Excessive Thirst □ Fatigue □ Fevers
□ Insomnia □ Low Sex Drive □ Night Sweats □ Weakness
□ Unexplained Weight Gain □ Unexplained Weight Loss

Eyes:

□ Recent Visual Changes

Ears/Nose/Throat/Neck:

□ Dental Problems □ Earaches □ Hearing Problems □ Nosebleeds
□ Recurrent Sore Throats □ Ringing in the Ears □ Sinus Problems

Cardiovascular:

□ Bleeding Disorder □ Chest Pain □ Deep Vein Thrombosis □ Fainting
□ High Blood Pressure □ Irregular Heartbeat □ Lightheadedness □ Swelling in the feet
□ Shortness of Breath During Sleep

Respiratory:

□ Cough □ Wheezing □ Pulmonary Embolism
□ Shortness of Breath on Exertion □ Shortness of Breath at Rest

Gastrointestinal:

□ Abdominal Cramps □ Acid Reflux □ Constipation □ Coffee Grounds Appearance in Vomit
□ Vomiting □ Diarrhea □ Hernia □ Dark and Tarry Stools

Musculoskeletal:

□ Back Pain □ Joint Pain □ Joint Stiffness □ Joint Swelling
□ Muscle Spasms □ Neck Pain

Genitourinary/Nephrology:

□ Blood in Urine □ Decreased Urine Flow/Frequency/Volume
□ Erectile Dysfunction □ Flank Pain □ Painful Urination □ Pelvic Pressure

Neurological:

□ Dizziness □ Headache □ Instability when walking □ Carpal Tunnel Syndrome
□ Numbness/Tingling □ Seizures

Psychiatric:

□ Depressed Mood □ Feeling Anxious □ Stress Problems
□ Suicidal Planning □ Suicidal Thoughts