US Pain & Spine Surgical Institute™

Follow Up

Date of visit: _____

Patient: _____ **Date of birth:** _____

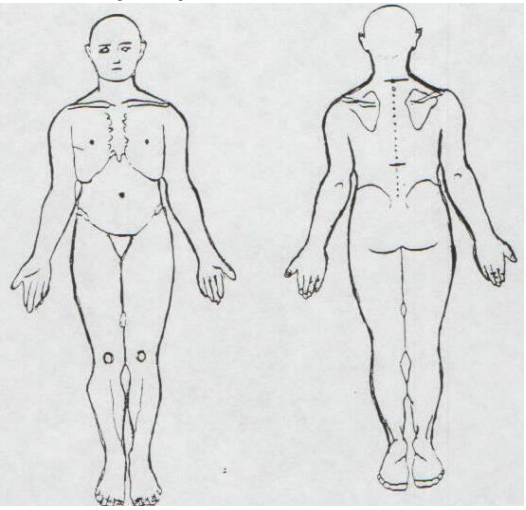
Pain/Chief Complaint: _____

How long have you had this pain? _____

Has the pain changed in intensity and/or character since your last visit? YES or NO If YES, please describe:

_____

Where is your pain located?(in the shaded diagram, mark worst spot with an "X")



PAIN SCALE

Over the last week, rate:

	None										Worst
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

Office use only:
Vital signs
Temp: _____
Pulse: _____
Resp: _____
BP:_____SP:____
Wt:_____Ht:____
Taken by: _____

Did you recently have a procedure/ injection? **Yes No**
If yes, what type? _____

Did it help? **Yes No**
If Yes, what percentage of relief did you experience:
_____

Are you still experiencing radiating pain? **Yes No**
If Yes, please explain: _____
_____
_____

CURRENT MEDICATIONS:

Medications	Dose	Frequency

ALLERGY:
_____
Reaction:
_____

Is there anything else we can help you with today? _____
_____
_____
_____

Patient's Signature/ Person completing form: _____ Date: _____

If someone other than patient, please print name: _____