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willamette PAIN & SPINE

Patient Follow Up Visit Form

Patient Name: _____ Date of Birth: _____
Today's Date: _____ Primary Care Provider: _____

Reason for visit: _____

Please update us on your chief complaint/condition addressed at initial visit: (i.e. improvement in function, change in pain)

_____

_____

Treatments completed (Injections/Pain treatments, Physical therapy, Medication, etc.) _____

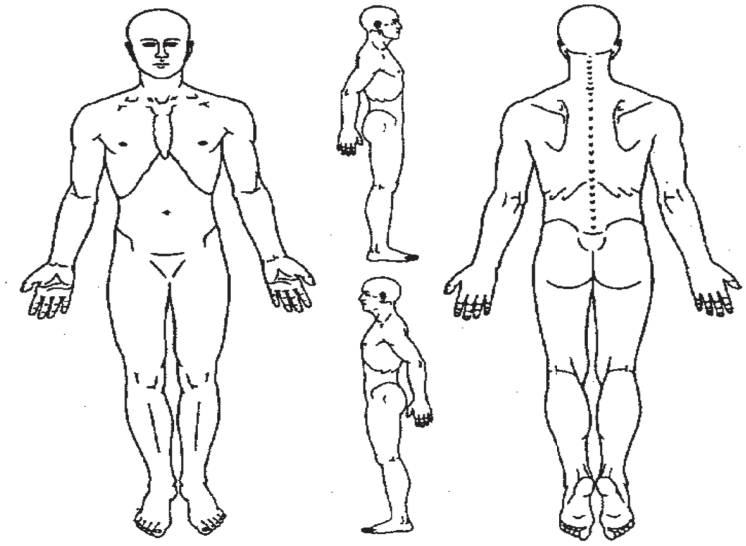
_____

Please describe the progression of your pain, overall: (Please circle)

Better	Worse	Unchanged/Stable

% of Improvement _____

On the diagram below, please mark where you are feeling your symptoms:
Mark "**P**" for Pain, "**N**" for Numbness, "**T**" for Tingling, "**B**" for Burning



How do you rate your pain? (Please circle on a scale of 0 to 10, 0 being none, and 10 being unbearable)

Current Pain Level:

0	1	2	3	4	5	6	7	8	9	10

Average Pain Level:

0	1	2	3	4	5	6	7	8	9	10

Pain Level at Best:

0	1	2	3	4	5	6	7	8	9	10

Pain Level at Worst:

0	1	2	3	4	5	6	7	8	9	10

Select one or more items below to describe the nature of your pain: (Please circle all that apply)

Sore	Shooting	Hot/Burning	Numbing	Other
Throbbing	Cramping	Stabbing	Dull/Achy	

What factors make your pain ***BETTER***? (Please circle all that apply, if "other" please describe)

Standing	Changes in Weather	Heat	Twisting	Rest
Walking	Lifting	Cold	Movement	Nothing
Sneezing	Lying down	Bending Forward	Changes in Position	Other:
Coughing	Sitting	Bending Backwards	Sex	

What factors make your pain ***WORSE***? (Please circle all that apply, if "other" please describe)

Standing	Changes in Weather	Heat	Twisting	Rest
Walking	Lifting	Cold	Movement	Nothing
Sneezing	Lying down	Bending Forward	Changes in Position	Other:
Coughing	Sitting	Bending Backwards	Sex	

When is the pain worst? (Please circle)

Morning	Afternoon	Evening	Night	Other

Females:
Are you Pregnant?

Yes	No	Not Sure

Patient's initials _____

List any changes regarding your Past Medical History, Past Surgical History, Family History, or Social history in the past 30 days *(smoking, drug use, alcohol use, living situation, occupation, marital status).*

_____

_____

List all **new** medications or **medication changes** since your last visit:

Medication	**Dose**	**Prescribing Physician**	**Medication**	**Dose**	**Prescribing Physician**
1)			4)		
2)			5)		
3)			6)		

Are there any **new** problems you would like to discuss today? _____

_____

_____

What do you want to accomplish from today's visit? (Please circle all that apply)

Diagnosis	X-ray	Medication management	Injection
Treatment Options	MRI	Review Test	Other

Please share any other information you would like us to know: _____

I ACKNOWLEGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE

_____ _____ _____

Patient or Legal Guardian Signature | Print Name | Date

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PAIN & SPINE

Instructions: Please place a check in the box beside any of the following symptoms that you have experienced or currently are experiencing within the last month.

☐ Fever ☐ Chills ☐ Weight Problems ☐ Fatigue ☐ Weakness ☐ Night Sweats	☐ Hearing Loss ☐ Ringing in Ears ☐ Ear Pain ☐ Nose Bleed ☐ Runny Nose	☐ Vision Problems ☐ Eye Pain ☐ Eye Redness ☐ Eye Swelling ☐ Eye Discharge ☐ Rash around Eyes	☐ Chest Pain ☐ Palpitations ☐ Pain when Walking ☐ Leg Swelling
☐ Cough ☐ Shortness of Breath ☐ Wheezing	☐ Abdominal Pain ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in Stool ☐ Painful Swallowing	☐ Pain Urination ☐ Frequency ☐ Urgency ☐ Incontinence ☐ Increased Urination ☐ Stones ☐ Hematuria (Blood in urine)	☐ Ejaculatory ☐ Dysfunction ☐ Erectile Dysfunction ☐ Menstrual ☐ Cramps/Pain with Menses ☐ Pain with Sexual Intercourse
☐ Neck Pain ☐ Back Pain ☐ Joint Pain/Laxity ☐ Muscle Pain ☐ Muscle Spasms ☐ Recent Falls	☐ Easy Bruising or Bleeding ☐ Excessive Thirst ☐ Temperature Intolerance ☐ Hot Flashes ☐ Excessive Hunger ☐ Rash Itching ☐ Lesions	☐ Dizziness ☐ Double Vision ☐ Numbness ☐ Tingling ☐ Light Headed ☐ Weakness ☐ Seizures ☐ Loss of Consciousness ☐ Headache	☐ Depression ☐ Suicidal Thoughts ☐ Thoughts of harming others ☐ Anxiety ☐ Trouble sleeping ☐ Memory Loss

Initials_____