## FOLLOW-UP VISIT Intake questionnaire





Please complete	all parts	of this c	questionna	ire, eve	n if nothi	ng has c	hanged	since ye	our last v	/isit.		
Name:	me: DOB: Today						's Date:	:				
Has your medica	al covera	age cha	anged fro	m your∣	last visi	t?	□Yes	□No				
<b>REASON FOR</b>	TODAY	'S VIS	IT									
□Medication □Review EM		Results	⊡Medica □Reviev		U						w MRI Results	_
PAIN DESCRI	PTION											
Where is your w	orst pai	<b>n?</b> (Cheo	ck one locatio		Back Abdomei	⊡Nec n ⊡Che		lead ⁼oot/Kn∉	ee/Leg	⊡Han ⊡Pelv	d/Shoulder/Arm is	
Check each num	nber bel	ow to ir	ndicate th	e level o	or intens	sity of y	our pair	<b>1.</b> (0=No l	⊃ain, 10=W	/orst Pain	)	
1: Very mind 2: Annoying 3: Distracting 4: Can be ig 5: Unable to 6: Cannot ig 7: Hard to fo 8: Physical a 9: Unable to 10: Unconso	and dist g more o nored if ignore the nore the cus on ta activity is speak, o	ften tha you are ne pain pain bu asks, in severe crying/m	In not focused o for more t able to v terferes w ly limited, a noaning in	han 30 r vork and ith sleep able to r pain une	ninutes participa , but still ead and	ate in va able to talk with	rious ac take car no diffic	e ofyou culty	rself			
Usually	□0	□1	□2	□3	□4	□5	□6	□7	□8	□9	□10	
Worst pain	□0	□1	□2	□3	□4	□5	□6	<b>□7</b>	□8	□9	□10	
Least pain Right now	□0 □0	□1 □1	□2 □2	□3 □3	□4 □4	□5 □5	□6 □6	□7 □7	□8 □8	□9 □9	□10 □10	
<b>CHANGES SIN</b>	CE YO	JR LAS	ST VISIT									
Is there any pos	sibility y	vou cou	Id be pre	gnant?	□Yes	□No	□N/A					
Do you have any	/ new pa	in com	plaints si	nce yoı	ır previc	ous visit	you wo	ould like	e to disc	uss tod	l <b>ay?</b> □Yes □I	٩V
Since your previ	ious visi	t, how	has your	pain ch	anged?	□Decr	eased	□Incre	eased	⊡Stay	ed the Same	
If you had a proc	cedure,	how mu	uch pain r	elief dia	d you ob	otain?						
□Did not have	procedu	re ⊡No	ne ⊡10%	□20%	□30%	□40%	□50%	□60%	□70%	□80%	6 □90% □100	%

Were there any problems? DYes DNo If yes, please explain \_\_\_\_\_

-OVER

## Have you developed any new:

Constitutional	□Fevers	□Chills	□Weight	Gain	□Weight Loss	□Fatigue	□Night Sw	/eats
Cardiovascular	<sup>.</sup> □Fainting	□DVT	□Chest F	Pain	□Irregular Heart	beat	□Foot Swe	elling
Gastrointestina	l ⊡Abdomin	al Cramps	□Heartbi	urn	□Constipation	□Diarrhea	□Nausea	□Vomiting
Respiratory	□Cough	□Wheezir	ng	□Pulm	onary Embolism	□Shortnes	s of Breath	
Psychiatric	□Suicidal <sup>·</sup>	Thoughts		□Depr	essed Mood	□Anxious I	eeling	

□I have not developed any new problems with any of the above conditions since my last visit.

## **CURRENT MEDICATIONS**

-	nedications since your last office visit:					
Are you currently tal	king any blood-thinners? □Yes □No					
n the last 30 days, have you been prescribed pain medication from another provider? □Yes □No						
Last dose of medication: □Today □Last night □2 nights ago □> 1 Week						
Pain relief from medications:						
I am stable on my current medication regimen. □Yes □No						
My medications help to improve my functioning and quality of life. □Yes □No						
MEDICATION SID						
Ū.	□Vomiting □Drowsiness □Dizziness □Dry Mouth □Confusion □Constipation □I do not have any side effects from my medications. Date:					
	DO NOT WRITE IN THIS SECTION					
Vitals:	T BP P WT HT					
PMP reviewed:	□Yes □No UDS completed? □Yes □No					
Imaging: DMRI	□CT □X-ray □Cervical □Lumbar □Hip □Knee □Other					
EMG/NCS: Arm	□Leg					
Medications:	□Refill all □Changes as follows					
Follow-up: □4 wee	eks					