FOLLOW-UP VISIT
INTAKE QUESTIONNAIRE

COMPREHENSIVE PAIN & NEUROLOGY CENTER PLLC
RELIEVE PAIN AND RECLAIM LIFE

Please complete all parts of this questionnaire, even if nothing has changed since your last visit.

Name: _____ **DOB:** _____ **Today's Date:** _____

Has your medical coverage changed from your last visit? ☐Yes ☐No

REASON FOR TODAY'S VISIT

☐Medication Refill ☐Medication Change ☐Post-Procedure Assessment ☐Review MRI Results
☐Review EMG/NCS Results ☐Review Lab Results ☐In-Office Procedure ☐Other_____

PAIN DESCRIPTION

Where is your worst pain? (Check one location) Back Neck Head Hand/Shoulder/Arm Abdomen Chest Foot/Knee/Leg Pelvis

Check each number below to indicate the level or intensity of your pain. (0=No Pain, 10=Worst Pain)

0: Pain free
1: Very minor
2: Annoying and distracting at times
3: Distracting more often than not
4: Can be ignored if you are focused on other tasks, but still distracting
5: Unable to ignore the pain for more than 30 minutes
6: Cannot ignore the pain but able to work and participate in various activities
7: Hard to focus on tasks, interferes with sleep, but still able to take care of yourself
8: Physical activity is severely limited, able to read and talk with no difficulty
9: Unable to speak, crying/moaning in pain uncontrollably, near delirium
10: Unconscious, pain makes you pass out

Usually	0	1	2	3	4	5	6	7	8	9	10
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
Right now	0	1	2	3	4	5	6	7	8	9	10

CHANGES SINCE YOUR LAST VISIT

Is there any possibility you could be pregnant? ☐Yes ☐No ☐N/A

Do you have any new pain complaints since your previous visit you would like to discuss today? ☐Yes ☐No

Since your previous visit, how has your pain changed? ☐Decreased ☐Increased ☐Stayed the Same

If you had a procedure, how much pain relief did you obtain?

☐Did not have procedure ☐None ☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Were there any problems?☐Yes ☐No If yes, please explain _____

-OVER

Have you developed any new:

Constitutional ☐Fevers ☐Chills ☐Weight Gain ☐Weight Loss ☐Fatigue ☐Night Sweats

Cardiovascular ☐Fainting ☐DVT ☐Chest Pain ☐Irregular Heartbeat ☐Foot Swelling

Gastrointestinal ☐Abdominal Cramps ☐Heartburn ☐Constipation ☐Diarrhea ☐Nausea ☐Vomiting

Respiratory ☐Cough ☐Wheezing ☐Pulmonary Embolism ☐Shortness of Breath

Psychiatric ☐Suicidal Thoughts ☐Depressed Mood ☐Anxious Feeling

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

CURRENT MEDICATIONS

Please list any new medications since your last office visit:

1. _____
2. _____
3. _____

Are you currently taking any blood-thinners? ☐Yes ☐No

In 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: ☐Minimal ☐Moderate ☐Significant

I am stable on my current medication regimen. ☐Yes ☐No

My medications help to improve my functioning and quality of life. ☐Yes ☐No

MEDICATION SIDE EFFECTS

Please check any of the listed side-effects you are experiencing, if any:

☐Nausea ☐Vomiting ☐Drowsiness ☐Dizziness ☐Dry Mouth ☐Confusion

☐Weight Gain ☐Constipation ☐I do not have any side effects from my medications.

Signature: _____ **Date:** _____

DO NOT WRITE IN THIS SECTION

Vitals: T _____ BP _____ P _____ WT _____ HT _____

PMP reviewed: ☐Yes ☐No **UDS completed?** ☐Yes ☐No

Imaging: ☐MRI ☐CT ☐X-ray ☐Cervical ☐Lumbar ☐Hip ☐Knee ☐Other _____

EMG/NCS: ☐Arm ☐Leg

Medications: ☐Refill all ☐Changes as follows _____

Follow-up: ☐4 weeks ☐Next available proc. ☐Next available EMG ☐Other_____

_____

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