

# Advanced Interventional Pain & Sports Medicine Center

## Follow-up

1. Name \_\_\_\_\_ Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_
2. Chief complaint \_\_\_\_\_
3. Present Pain Level 0 1 2 3 4 5 6 7 8 9 10 Since last visit, worst pain level \_\_\_\_\_ Best pain level \_\_\_\_\_
4. Has your pain increased, decreased or the same since last clinical visit? \_\_\_\_\_
5. Date of last clinical visit \_\_\_\_\_ Date of last injection \_\_\_\_\_
6. Has your function improved \_\_\_\_\_ Has your your daily activities improved since last visit. \_\_\_\_\_
7. How often is your pain present Occasional Frequent Constant 24 hours, 7 days \_\_\_/week \_\_\_/month
8. Is the pain Aching Burning Stabbing Pressure Throbbing Deep Cramping Other \_\_\_\_\_
9. Please **circle only one choice** given below:

• I have only back pain	• I have only neck pain
• I have only leg pain	• I have only arm pain
• Back pain is more than leg pain	• Neck pain is more than arm pain
• Leg pain is more than back pain	• Arm pain is more than neck pain
• Back pain is equal to leg pain	• Arm pain is equal to neck pain

**Do you have any?**

Tingling Yes No Where \_\_\_\_\_

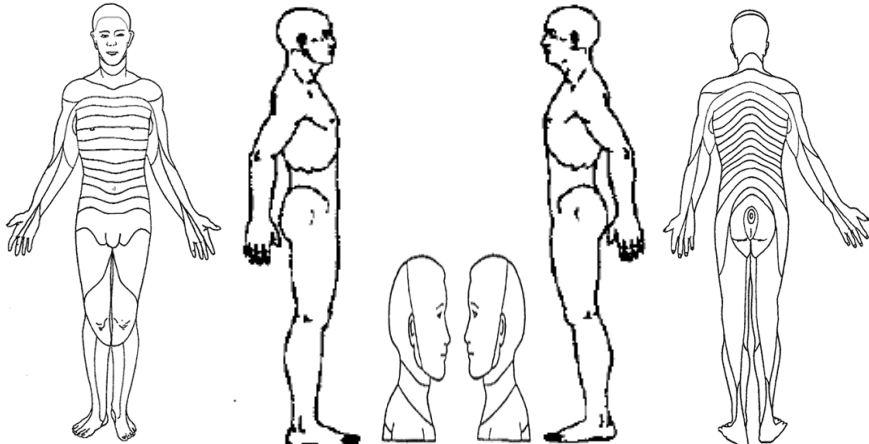
Numbness Yes No Where \_\_\_\_\_

Weakness Yes No Where \_\_\_\_\_

10. **What worsens your pain:**  
Sitting standing walking bending driving lying on back Lying on stomach lying on the side sitting-to-standing coughing
11. **What decreases your pain:**  
Sitting standing walking bending lying on back Lying on stomach lying on the side Heat Ice medication
12. **Current Medications:** (Any change in medications since last visit?) \_\_\_\_\_
13. **Any reduction or increase in pain medication?** \_\_\_\_\_
14. **Medical Problems:** Diabetes Hypertension Stroke Thyroid Heart Kidney Seizures Bleeding Liver Circulation HIV Reflux Pacemaker Defibrillator Asthma Hepatitis Murmur High cholesterol Ulcer COPD

15. Please **circle** if you have any of the following medical problems

- General :** weight change, fevers fatigue
- Eyes:** glasses or contacts
- E.N.T.:** hearing aid, dental, trouble swallowing
- Cardiovascular** chest pain, blood clots, swelling
- Respiratory :** wheezing, shortness of breath
- Gastrointestinal:** ulcers, heartburn, bleeding
- Genitourinary:** infections, night time urination
- Musculoskeletal:** arthritis, gout, osteoporosis
- Integument:** breast lumps, mass, rash
- Neurologic:** fainting, seizures, stroke,
- Psychological:** depression, anxious
- Endocrine:** spontaneous temp. changes
- Hem/lymp:** anemia, bleeding problems
- Immunology:** HIV, Lupus



**Indicate the location of your pain with the following signs**

Aching ^^^^      Stabbing ////      Burning xx      Numbness oo      Tingling >>

Pressure #####      Other \*\*

Smoking Yes/No \_\_\_\_\_ How much \_\_\_\_\_

16. **Any new medical problems since last clinical visit** \_\_\_\_\_
17. **Allergies:** \_\_\_\_\_ **Location** \_\_\_\_\_ **Severity** \_\_\_\_\_ **Reaction** \_\_\_\_\_
18. **Do you exercise? Yes/No** Walk Bicycle Treadmill \_\_\_\_\_ **How many times a week?** \_\_\_\_\_ **For how long** \_\_\_\_\_
19. **Work Status** Full time Part time \_\_\_\_\_ **Restrictions** \_\_\_\_\_ **Not working** \_\_\_\_\_

To be completed by the physician

20. Physical Examination: Flex, Extension. Rotation
21. Radiology reports: MRI X-rays: Films Report
22. Diagnosis
23. Treatment Plan Medication Injection Booklet PT

**For Office use**

Booklet      Surgery center      Ultrasound      EMG      Injection at office      Follow up