Name:
DOB: Age:
Chart: Date:

Follow - Up

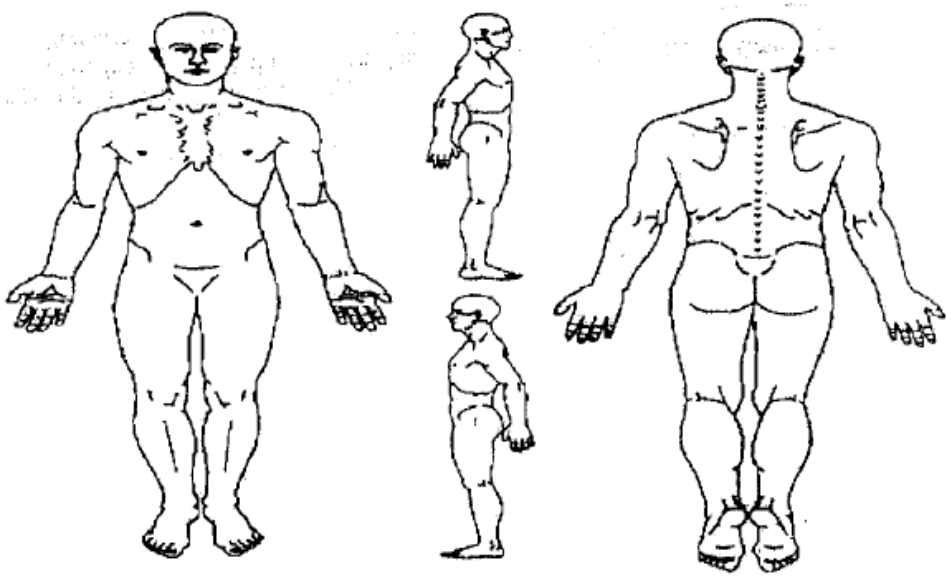
(1) DATE: _____

(2) PATIENT: _____

(3) What is your **MAIN** pain complaint today? _____

(4) On a scale of 1 to 10, (10 being the worst pain imaginable) what is your pain TODAY?
(Please Circle) 0 1 2 3 4 5 6 7 8 9 10

(5) On the diagram below, place an **"X"** where pain is located and an **"O"** where numbness is located:



(6) Is / are the treatments helping you function better? Yes No
What is an activity that you are able to do because of the treatment you are receiving? _____

(7) Your pain is present: (Circle best answer) Constantly Frequently Intermittently Never

(8) Describe your pain: (Circle all that apply)
Burning Shooting Stabbing Tingling Throb Numbness Cramping
Dull Pressure Ache Electric-like Other_____

(9) What makes your pain worse? (Circle all that apply)
Sitting Standing Walking Coughing/Sneezing Bowel movements Lying down Other_____

(10) What makes it better? (Circle all that apply)
Rest Massage Acupuncture Physical Therapy Injections Chiropractic Medications

(11) Has your sleep improved since last visit? Yes No
(12) Are you constipated? Yes No
(13) Do you feel tired or sedated during the day? Yes No
(14) Mood improved? Yes No
(15) Do you smoke? Yes No
(16) Has your activity increased since last visit? Yes No
(17) Are you working? Yes No

(18) LIST CURRENT PAIN MEDICATIONS: