Follow Up Evaluation

Date: _____ Patient Name: _____ PT DOB: _____

Since your last visit have you:
Felt stress, anxiety, or depressed? **O** No **O** Yes Had any changes to medication? **O** No **O** Yes
Been diagnosed with a new disorder? **O** No **O** Yes Had surgery? **O** No **O** Yes

If you received an injection at your last visit, what was your pain relief?
O Greater than 50% **O** Less than 50%

And did it last for:
O Greater than 2 weeks **O** Less than 2 weeks

Female Patients; Are you now or do you believe you could be pregnant?
O No **O** Yes, Unconfirmed **O** Yes, Confirmed

Where is the location of your pain? _____

What is the frequency of your pain? **O** Constant **O** Fluctuating/ALWAYS present **O** Fluctuating/USUALLY present **O** Fluctuating/RARELY present

What best describes your pain? **O** Aching **O** Burning **O** Cramping **O** Dull **O** Numb **O** Sharp **O** Stabbing **O** Stinging **O** Throbbing **O** Tingling

What is your pain level most of the time?
O - No Pain **O** 1 **O** 2 **O** 3 **O** 4 **O** 5 **O** 6 **O** 7 **O** 8 **O** 9 **O** 10 **–** Unbearable Pain

What makes your pain worse? **O** Bending **O** Changing from sitting to standing **O** Sitting **O** Laying on side **O** Lifting or carrying HEAVY loads **O** Lifting or carrying SMALL loads **O** Laying on back

What makes your pain better? **O** Laying on side **O** Laying on my back **O** Sitting **O** Standing **O** Walking **O** Stretching **O** Exercise **O** Nothing

What does your pain interfere with? **O** Daily Chores **O** Employment **O** Exercise **O** Grooming **O** House Chores **O** Mood **O** Sleep **O** Relationships **O** Walking **O** Nothing

How much pain relief do you have from your current pain medication? **O** None **O** Mild **O** Moderate **O** 0-10% relief **O** 11-25% Relief **O** 26-45% Relief **O** 46-65% Relief **O** 66-85% Relief **O** 86-100% Relief

What activities can you perform due to current pain medication relief? **O** Employment Duties **O** Exercise **O** Social outings **O** Shopping **O** Cooking **O** Childcare **O** Hobbies **O** Personal Hygiene

Do your current pain medications cause any of these adverse effects? **O** None **O** Vision Change **O** Dizziness **O** Fogginess **O** Appetites Change **O** Weight Change **O** Forgetfulness **O** Itching **O** Nausea **O** Sleepiness **O** Constipation

How compliant are you with taking your pain medications? **O** As Prescribed **O** Fair **O** Poor **O** Sporadic

Feeling addicted to the opioids? **O** Yes **O** No **Giving away the prescription opioids?** **O** Yes **O** No

Selling the prescription opioids? **O** Yes **O** No **Using the analgesics for anything other than pain relief?** **O** Yes **O** No

Please mark each of the following symptoms/problems that you are currently having. (Mark ALL that apply)

General:
O Weight loss
O Weight gain
O Fever
O Night Sweats
O Fatigue

Genitourinary
O Painful urination
O Blood in urine
O Enlarged prostate

HEENT
O Headache
O Sinusitis
O Hearing Loss

Endocrine/Hematological
O Abnormal Blood Sugars
O Easy Bruising

Vascular
O Swelling in legs

Respiratory
O Shortness of breath
O Sleep Apnea
O C-PAP

Musculoskeletal
O Joint pain
O Muscle Spasm
O Neck Pain
O Back Pain

Skin
O Rash

Cardiology
O Chest Pain
O Irregular Heartbeat
O High Blood Pressure

Neurology
O Drowsiness
O Dizziness
O Seizures
O Weakness
O Numbness

Gastroenterology
O Appetite Loss
O Chronic Nausea
O Heartburn
O Constipation

Psychiatric
O Depression
O Anxiety Attacks
O Blackouts
O Insomnia