Follow-Up Patient Form

Name: _____ Date: _____

Referring Physician _____

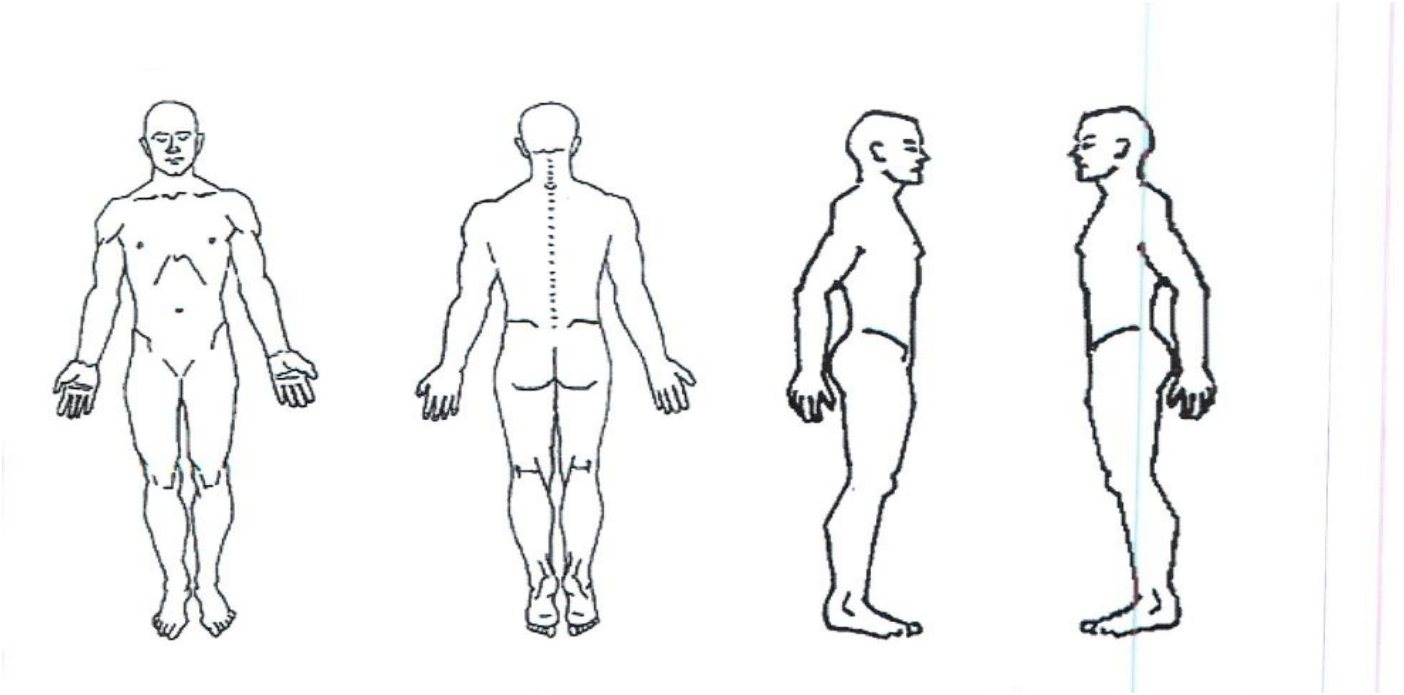
Primary Care Physician _____

Please List All Current Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you take Coumadin/Warfarin/Plavix/Lovonox or Aspirin? Yes_____ No_____ Last dose?_____

Please shade in the areas where you have pain



Characteristics of your pain

Pain Intensity (0 no pain, 10 worst pain ever)
Please list number that best describes you pain

Average Pain 0 1 2 3 4 5 6 7 8 9 10
Worse Pain 0 1 2 3 4 5 6 7 8 9 10
With Activity 0 1 2 3 4 5 6 7 8 9 10

Associated Systems please circle if applies to you

I do not have any other symptoms
Fatigue
Loss of bowel/bladder control
Nausea
Numbness
Tingling, burning, or pricking feeling
Spasm
Weakness

What percentage of improvement did you get from your last procedure/treatment? _____

Circle activities that make pain worse

All Activities
Bending Forward
Exertion/Exercise
Getting out of chair
Lifting
Lying Down
Moderate Physical activity
Nonspecific activity
Position Change
Reaching
Significant Physical Activity
Sitting
Standing
Turning the Head
Twisting
Walking
Other _____

Circle things activities that make pain better

None
Bending Forward
Injections
Lying down
Medications
Moving
Position Change
Physical Activity
Procedures
Rest
Sitting
Standing
Other _____

Circle the qualities of your pain

Aching
Burning
Dull
Sharp
Shooting
Stabbing
Throbbing
Pressure
Crushing
Cramping
Spasmodic
Pulling
Tender
Tight
Knife like
Hot
Sore

Circle the duration of your pain

Constant
Intermittent

If you are allergic to anything please list below: