COMPLETE FOR EVERY FOLLOW-UP VISIT

Patient Name: _____ **DOB:** _____

1. WHAT IS YOUR MAIN FOCUS TODAY? (CHECK ALL THAT APPLY)

◯ Medication Refill ◯ Discuss Injections ◯ New Pain

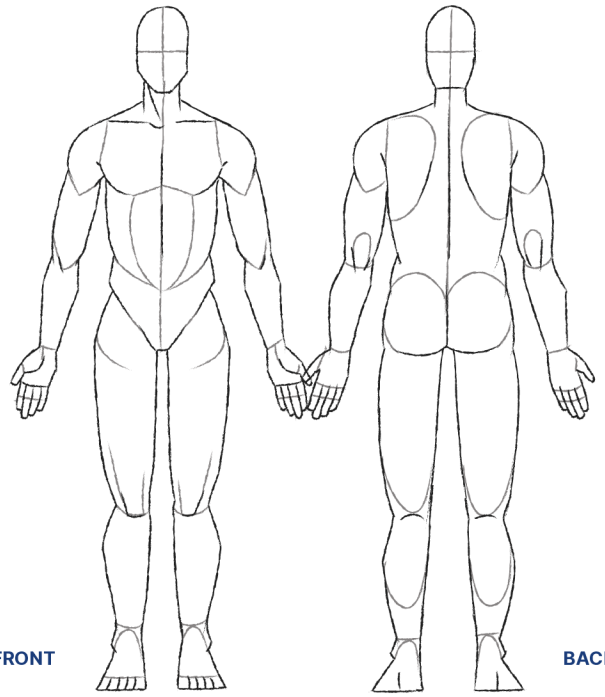
2. CURRENT LEVEL OF PAIN (0-10) (10 IS WORST)

0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

3. ANY NEW ALLERGIES, MEDICAL CONDITIONS, OR MEDICATIONS SINCE YOUR LAST VISIT? ◯ No ◯ Allergies ◯ Medical Conditions ◯ Meds

_____

On the diagram, shade the areas where you feel pain. Place an "X" on the area that hurts most.



FRONT BACK

4. DESCRIBE THE FREQUENCY OF YOUR PAIN

◯ Intermittent ◯ Constant
◯ Occasional ◯ Rare

5. WHAT MAKES YOUR PAIN WORSE?

◯ Movement ◯ Walking
◯ Sitting ◯ Standing
◯ Stress ◯ Other:

6. WHAT RELIEVES YOUR PAIN? (CHECK ALL THAT APPLY)

◯ Exercise ◯ Physical Therapy ◯ Medications ◯ Injections
◯ Sitting ◯ Rest ◯ Heat ◯ Ice
◯ Other: _____

_____

7. HOW WOULD YOU DESCRIBE YOUR PAIN? (CHECK ALL THAT APPLY)

◯ Aching ◯ Dull ◯ Sharp ◯ Shooting
◯ Stabbing ◯ Throbbing ◯ Deep ◯ Numbness
◯ Piercing ◯ Tingling ◯ Piercing ◯ Radiating
◯ Other: _____

_____

PAIN SCALE

0	1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Does not interfere										Completely interferes

9. USE THE SCALE TO RATE YOUR PAIN IN THE LAST WEEK

	0	1	2	3	4	5	6	7	8	9	10
Worst pain in the last week	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Least pain in the last week	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Average pain in the last week	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

10. USE THE SCALE TO INDICATE HOW PAIN HAS INTERFERED WITH THE FOLLOWING IN THE LAST WEEK

	0	1	2	3	4	5	6	7	8	9	10
General Activity	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Mood	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Walking Ability	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Normal Work	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Relations with Other People	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sleep	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Enjoyment of Life	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

↓ TURN PAGE OVER ↓

11. SINCE YOUR LAST OFFICE VISIT, CHECK ALL THAT APPLY

- ◯ Started a new blood thinner
- ◯ Had new imaging (MRI/CT/X-Ray
- ◯ Attended Physical Therapy
- ◯ Been to the ER or hospitalized
- ◯ Had a new fall/injury/surgery

12. DO YOU HAVE ANY IMPLANTED HARDWARE? CHECK ALL THAT APPLY

- ◯ SCS Implant
- ◯ Joint Implants (hip/knee/shoulder)
- ◯ Pacemaker/Defibrillator
- ◯ Other: _____
- ◯ Spinal hardware (screws/rods/plates)

_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless	◯	◯	◯	◯
3. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating	◯	◯	◯	◯
6. Feeling bad about yourself - or that you are a failure	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading or watching TV	◯	◯	◯	◯
8. Moving or speaking so slowly that others noticed, or being fidgety/restless	◯	◯	◯	◯
9. Thoughts that you would be better off dead, or of hurting yourself	◯	◯	◯	◯

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

ADDITIONAL NOTES

_____

_____