Follow-Up Intake Paperwork

Your Name: _____ Date of Birth:_____
Today's Date: _____

Please carefully complete all sections of this form, even if nothing has changed since your last visit.

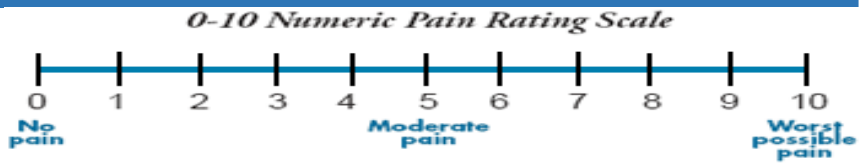
Has your medical coverage changed from your last visit? ❑ Yes ❑ No

Reason for Today's Visit

❑ Medication Refill ❑ Medication Change ❑ Post-Procedure Assessment
❑ Review MRI Results ❑ Review Test Results ❑ Other: _____

Pain Description

Please rate your pain using a 0 – 10 scale:



Check all that describe your pain today:

❑ Aching ❑ Shooting ❑ Burning ❑ Spasming ❑ Dull ❑ Tingling/pins and needles
❑ Hot/Burning ❑ Numb ❑ Stabbing/Sharp ❑ Shock-like ❑ Throbbing

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

Changes Since Your Last Visit

Have you developed any new pain complaints since your last visit you would like to discuss today? ❑ Yes ❑ No

Since your last appointment, how as your pain changed? ❑ Decreased ❑ Increased ❑ Stayed the same

If you had a procedure, how much pain relief did you obtain?
❑ None ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Were there any problems? ❑ Yes ❑ No
If yes, please explain:_____

Medication Effects

Mark the following medication side-effects you are experiencing, if any:

❑ Confusion ❑ Constipation ❑ Dizziness ❑ Drowsiness
❑ Dry Mouth ❑ Nausea ❑ Vomiting ❑ Weight Gain

❑ I do not have any adverse side effects from current medications.
❑ I am stable on my current medication regimen.
❑ My medications help to improve my functioning and quality of life.

Signature and Date

Signed: _____ Date: _____