RICHMOND SPINE Interventions & Pain Center

## ESTABLISHED PATIENTS: Follow-up Visit Form

**IMPORTANT:** Please complete all sections of this form. Do not leave any unanswered items. If the question does not apply, you may put "N/A".

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### Personal Information

Full Name

| | | |
|---|---|---|
| | | |
| First Name | Middle Name | Last Name |

Date of Birth

Today's Date

Date of Last Visit

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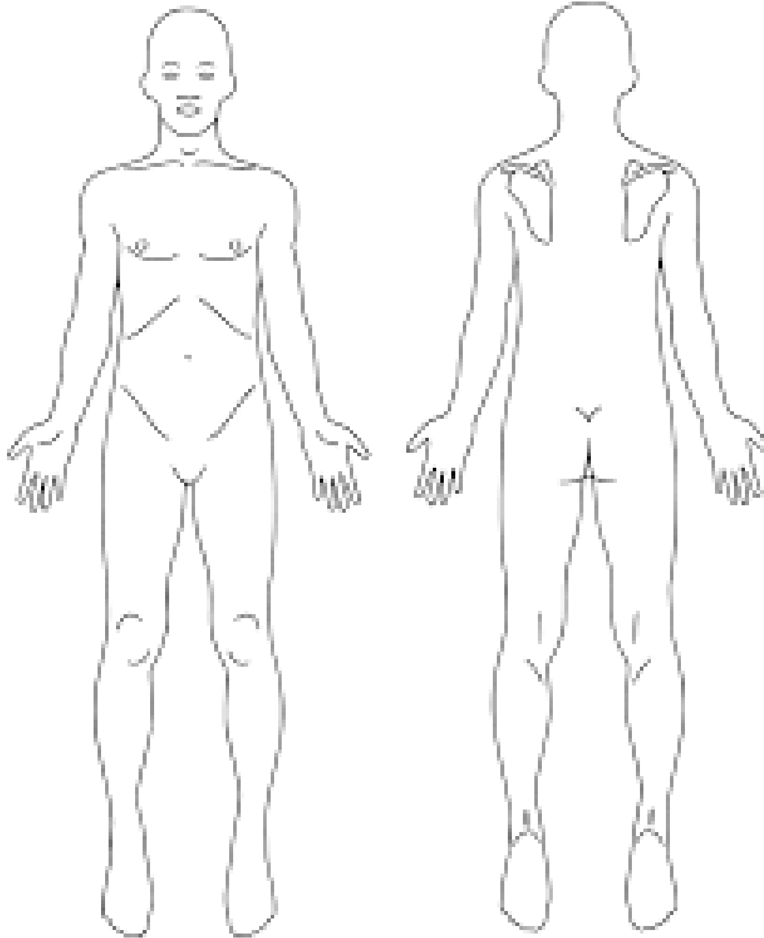
Reason for today's visit:

Location of your pain today

You may also help us visualize the location of your pain by shading the body part in the image provided below.



Pain radiates into?

- ☐ Right Arm
- ☐ Left Arm
- ☐ Right Leg
- ☐ Left Leg
- ☐ Pain does not radiate
- ☐ Other:________

Quality of pain:

- ☐ Aching
- ☐ Cramping
- ☐ Numbness
- ☐ Hot/Burning
- ☐ Tingling/Pins and Needles
- ☐ Throbbing
- ☐ Shock-like
- ☐ Shooting
- ☐ Spasming
- ☐ Dull
- ☐ Tiring/Exhausting
- ☐ Stabbing/Sharp
- ☐ Squeezing
- ☐ No Pain
- ☐ Other: ________

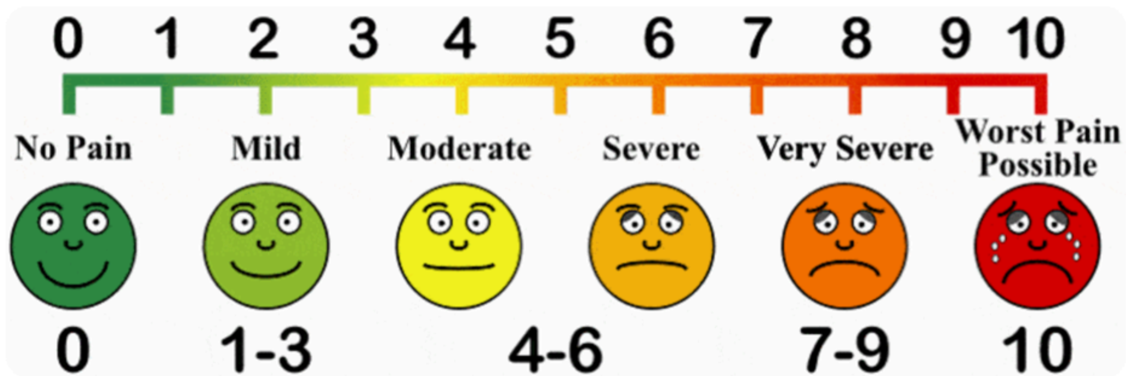
The following describes the pain frequency:

- ☐ Constant
- ☐ Intermittent (comes & goes)
- ☐ Changes in severity but always present
- ☐ No Pain

The pain is worse in?

- ☐ Mornings
- ☐ During the day
- ☐ Evenings
- ☐ Nights
- ☐ Middle of the night
- ☐ No Pain

On a scale of 0-10, **0 being no pain** and **10 being the worst pain** you can imagine.




Worst Pain (0 as no pain and 10 as the worst pain imaginable):

| | | |
|---|---|---|
| ☐ 0 | ☐ 4 | ☐ 8 |
| ☐ 1 | ☐ 5 | ☐ 9 |
| ☐ 2 | ☐ 6 | ☐ 10 |
| ☐ 3 | ☐ 7 | |

Pain Level Today (0 as no pain and 10 as worst pain imaginable):

| | | |
|---|---|---|
| ☐ 0 | ☐ 4 | ☐ 8 |
| ☐ 1 | ☐ 5 | ☐ 9 |
| ☐ 2 | ☐ 6 | ☐ 10 |
| ☐ 3 | ☐ 7 | |

Modalities currently used to treat the pain:

- ☐ Injections for pain
- ☐ Manipulation
- ☐ Home exercises
- ☐ Exercises in physical therapy
- ☐ Pain medications
- ☐ Muscle relaxant pills
- ☐ Aspirin/Anti-inflammatory pills
- ☐ Heat/Ice
- ☐ Cognitive-behavioral therapy
- ☐ Chiropractic care
- ☐ Acupuncture
- ☐ Aquatic Therapy
- ☐ Dry Needling
- ☐ Massage therapy
- ☐ Nothing
- ☐ Other: ________

Relief from the current medication regimen:

- ☐ 10%
- ☐ 20%
- ☐ 30%
- ☐ 40%
- ☐ 50%
- ☐ 60%
- ☐ 70%
- ☐ 80%
- ☐ 90%
- ☐ 100%
- ☐ No Relief

Other remarks:

Medications help improve function:

- ☐ Yes
- ☐ No

Medications help in performing the following activities:

- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Bathing
- ☐ Getting dressed
- ☐ Cleaning
- ☐ Cooking
- ☐ Lawn Care
- ☐ Laundry
- ☐ Sitting at Work
- ☐ Walking at Work
- ☐ Standing at Work
- ☐ School
- ☐ Home duties
- ☐ Child Care
- ☐ Dining outside
- ☐ Sports
- ☐ Currently not taking medications for the pain
- ☐ Other: ________

Side-effects experienced from medications:

- ☐ Confusion
- ☐ Constipation
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Dry Mouth
- ☐ Nausea
- ☐ Vomiting
- ☐ Weight Gain
- ☐ I do not have any adverse side effects from current medications
- ☐ Other: ________

Factors that reduce the pain:

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Injections for Pain
- ☐ Manipulation
- ☐ Home exercises
- ☐ Exercises in physical therapy
- ☐ Pain pills
- ☐ Muscle relaxant pills
- ☐ Aspirin/Anti-inflammatory pills
- ☐ Heat / Ice
- ☐ Nothing
- ☐ Other: _________

Activities that make the pain worse:

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Driving
- ☐ Standing
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backward
- ☐ Coughing
- ☐ Sneezing
- ☐ Reaching
- ☐ Lifting
- ☐ Nothing
- ☐ Other: _________

Activities that pain continues to interfere with despite current treatment/s:

- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Bathing
- ☐ Getting dressed
- ☐ Cleaning
- ☐ Cooking
- ☐ Lawn Care
- ☐ Laundry
- ☐ Sitting at Work
- ☐ Walking at Work
- ☐ Standing at Work
- ☐ School
- ☐ Home duties
- ☐ Child Care
- ☐ Dining outside
- ☐ Sports
- ☐ Nothing
- ☐ Other: _________

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Have you visited the emergency room since your last visit?

- ☐ Yes
- ☐ No

Date and name of the facility:

| |
|---|

Have you had a MRI Scan for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where the MRI was performed:

| |
|---|

Have you had a CT scan for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where the CT scan was performed:

Have you had an X-ray for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where the X-ray was performed:

Have you had any operations or procedures since your last visit?

- ☐ Yes
- ☐ No

Please describe briefly:

Have you been diagnosed with any new medical problems since your last visit?

- ☐ Yes
- ☐ No

Please describe briefly: