RichmondSpine Interventions & Pain Center

Established Patients: Post Procedure 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".

Personal Information

Full Name

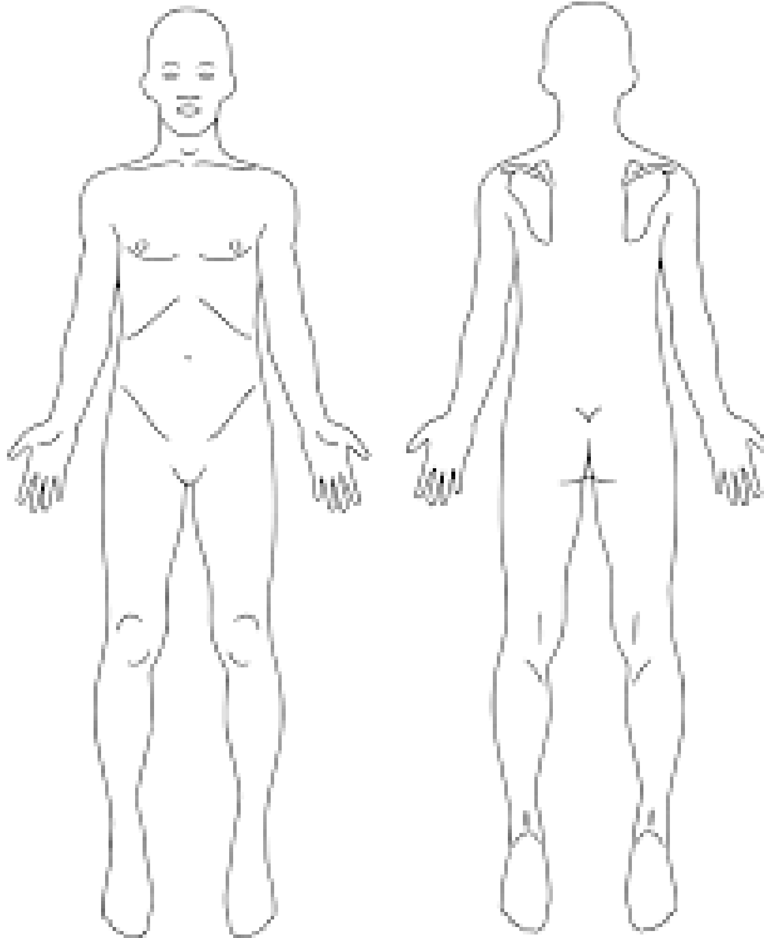
First Name	Middle Name	Last Name

Date of Birth

Today's Date

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.



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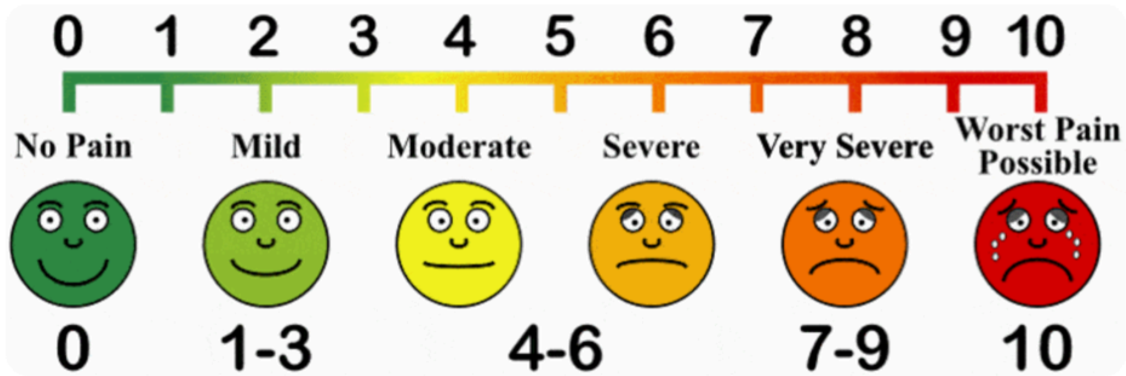
On a scale of 0-10, **0 being no pain** and **10 being the worst pain** you can imagine.



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

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

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

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

The procedure gave the following percentage of relief:

- ☐ Up to 29%
- ☐ 30 - 49%
- ☐ 50 - 69%
- ☐ 70 - 89%
- ☐ 90 - 100%
- ☐ No Relief

The duration of relief is/was:

- ☐ Less than one (1) week
- ☐ Three (3) weeks or longer
- ☐ More than 3 months
- ☐ Relief is still lasting
- ☐ Other: _________

The procedure helped 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
- ☐ None

Pain continues to interfere with 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
- ☐ None

Other treatment modalities used at present and since the procedure:

- ☐ Home exercises
- ☐ Physical therapy
- ☐ Pain medications
- ☐ Muscle relaxant pills
- ☐ Heat/Ice
- ☐ Cognitive-behavioral therapy
- ☐ Chiropractic care
- ☐ Acupuncture
- ☐ Aquatic therapy
- ☐ Dry Needling
- ☐ Massage therapy
- ☐ Nothing
- ☐ Other: ________

Have you visited the emergency room since your last visit?

- ☐ Yes
- ☐ No

Date and name of the facility:

Have you had MRI Scan for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where MRI was performed:

Have you had CT scan for this pain?

- ☐ Yes
- ☐ No

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

Have you had X-ray for this pain?

- ☐ Yes
- ☐ No

Date and name of the facility where 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: