FOLLOW-UP FORM

PLEASE ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE

NAME____ **DATE**________________

New phone #?__________________________ **New email address?**____________________________

WHERE IS YOUR PAIN TODAY? [ ]NECK [ ]LOWER BACK [ ]RIGHT LEG [ ]LEFT LEG
[ ]RIGHT ARM [ ]LEFT ARM OTHER____
SINCE LAST VISIT WHAT TREATMENTS HAVE YOU UNDERTAKEN? [ ]PHYSICAL THERAPY
[ ]CHIROPRACTIC [ ]ACUPUNCTURE [ ]MASSAGE [ ]HOME EXERCISE
[ ]OTHER___________________________[ ]NONE
WHICH AREAS ARE BEING TREATED? [ ]NECK [ ]LOWER BACK [ ]RIGHT LEG [ ]LEFT LEG
[ ]RIGHT ARM [ ]LEFT ARM OTHER____
ANY NEW INJURIES OR SURGERIES SINCE THE LAST VISIT? [ ]NO [ ]YES
IF YES, PLEASE DESCRIBE:____
ARE YOU EXPERIENCING: [ ]NUMBNESS [ ]TINGLING [ ]PINS and NEEDLES SENSATIONS [ ]BURNING?
IF YES, WHERE? [ ]NECK [ ]LOWER BACK [ ]RIGHT LEG [ ]LEFT LEG
[ ]RIGHT ARM [ ]LEFT ARM OTHER____
DOES THE PAIN RADIATE? [ ]YES [ ]NO **IF YES, WHERE?**
[ ]NECK [ ]LOWER BACK [ ]RIGHT LEG [ ]LEFT LEG [ ]RIGHT ARM [ ]LEFT ARM
OTHER____
ANY NEW MEDICATIONS FROM <u>OTHER</u> PROVIDERS? [ ]NO [ ]YES IF YES, PLEASE
DESCRIBE:__________________________ PRESCRIBED BY DOCTOR________________________
ARE YOU BEING PRESCRIBED PAIN MEDICATION BY THIS OFFICE? [ ]YES [ ]NO
IF YES, ARE YOU TAKING THE MEDICATION AS PRESCRIBED? [ ]YES [ ]NO [ ]N/A
IF NO, PLEASE DESCRIBE:____
ANY ILLICIT (RECREATIONAL) DRUG USAGE? [ ]NO [ ]YES DESCRIBE___________________________
ARE YOU CURRENTLY WORKING? [ ]YES [ ]NO DESCRIBE_________________________________
ON A SCALE FROM 0-10 WITH 0 BEING NO PAIN AND 10 BEING EXCRUCIATING, UNBEARABLE PAIN,

HOW WOULD YOU RATE YOUR PAIN AT THE MOMENT? 0 1 2 3 4 5 6 7 8 9 10

<u>INJECTION SPECIFIC FOLLOW-UP</u>

DID YOU HAVE AN INJECTION AT YOUR LAST VISIT? [ ]YES [ ]NO **IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:**

BY WHAT PERCENTAGE DID YOUR PAIN DECREASE AS A RESULT OF THE INJECTION?______%
FOR HOW LONG? _______________________ [ ]WEEKS [ ]DAYS or [ ]PAIN RELIEF IS ONGOING
ARE YOU TAKING LESS 'AS NEEDED' PAIN MEDICATION SINCE THE INJECTION? [ ]YES [ ]NO [ ]n/a
WHAT ACTIVITIES CAN YOU NOW DO BETTER SINCE YOUR INJECTION? [ ]BENDING [ ]LIFTING
[ ]DRIVING [ ]SITTING [ ]STANDING [ ]COMPUTER WORK [ ]HOUSEWORK [ ]WORK DUTIES
[ ]PERSONAL HYGIENE [ ]WALKING [ ]COOKING [ ]CHILDCARE [ ]SLEEPING
[ ]OTHER____

COMMENTS:____

PLEASE SIGN X______________________________