Name: _____Date of Birth: _____Date: _____

Spine & Nerve Diagnostic Center Follow-up Pain Assessment

Please mark the diagram to the right where you feel pain or sensation using the symbols indicated

Please rate the severity of pain you are currently experiencing on a scale of 0 -10, with 0 being no pain and 10 being the worst pain imaginable.

Pain level without medications
0 1 2 3 4 5 6 7 8 9 10

Pain level with medications
0 1 2 3 4 5 6 7 8 9 10

Have you had any new treatment, imaging, or procedures since your last visit? if so, please list:

_____ _____

Chief Complaint/Reason for Appointment?

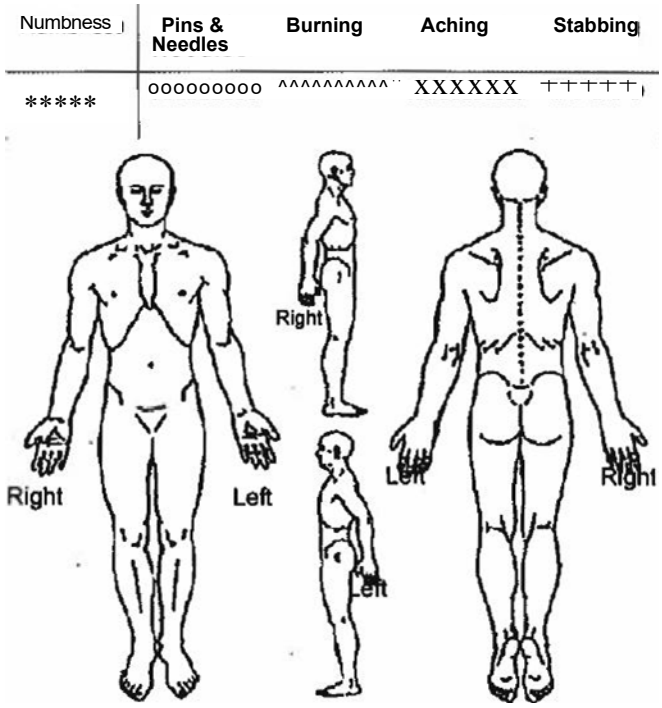
_____

What medications are you currently taking/any CHANGES?

_____ _____

Do you have any med allergies?

_____ _____



What are your symptoms since your last visit? (circle all that apply):

Cardiovascular	**Leg/Ankle Swelling**					
Constitutional	**Fever**	**Chills**				
Gastrointestinal	**Nausea/Vomiting**	**Stool incontinence (loss of control of your stool) Heart burn**				
Genitourinary	**Any loss of control of urine? Y or N. If Yes, what are your symptoms:**					
Musculoskeletal	**Joint Pain**	**Muscle Pain**	**Joint Swelling**	**Muscle Weakness**	**Muscle Spasm**	**Stiffness**
Neurological	**Migraines**	**Numbness**	**Dizziness**	**Headaches**	**Loss of Balance**	
Psychological	**Depression**	**Anxiety**	**Insomnia**			

What is your work status? (Circle all that apply):
Working full duty Working modified duty Working part-time Not working Retired

What is your job title? _____

What activities make your condition worse? (Circle all that apply):
Sitting Standing Walking Bending Lifting Laying down

What activities make your condition better? (Circle all that apply):
Sitting Standing Laying down Medications Injections Physical therapy

Circle all of the following that apply to you.
Single Married In a relationship Smoker Non-smoker Drink alcohol rarely Drink alcohol often Never drink alcohol

Compared to your last visit, how is your pain level? (Circle one): Better Worse Same

Who is your primary care physician? _____

Is there any chance you may be pregnant? (Circle One) YES NO

FOR OFFICE USE ONLY:	Height:	Weight:	**Temperature:**
	Blood Pressure:	Heart Rate:	
Allergies to iodine?	YES NO		
Any chance of pregnancy?	YES NO		
Diabetic	YES NO	B/S:	