Personalized
PAIN AND SPINE CARE

FOLLOW UP NOTE

1) Referring Physician _____

Primary Care Physician (if not the same) _____

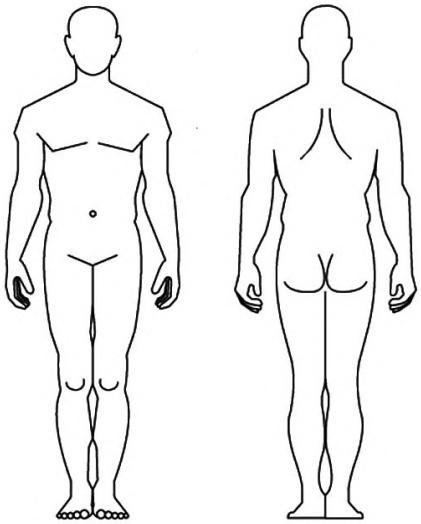
Patient Information

2)_____
Last Name First Name M.I.

2a) Age: _____ 2b) Sex: ☐ M ☐ F 3a) When was your last visit? _____

3b) Please describe pain condition since last visit _____

PAIN LOCATION



Front *Back*

Please mark the location(s) of your pain on the diagrams above with an "X".

4) TIMING OF PAIN

How often do you have your pain? (please check one)

☐ Constantly (100% of the time) ☐ Frequently (75% of the time)
☐ Intermittently (50% of the time) ☐ Occasionally (25% of the time)

5) PAIN QUALITY

How would you describe the pain? (Choose as many are applicable)

☐ Burning ☐ Sharp ☐ Cutting ☐ Throbbing
☐ Cramping ☐ Numbness ☐ Dull, Aching ☐ Pressure
☐ Pins & Needles ☐ Shooting ☐ Electric-like ☐ Other_____

6) PAIN INTENSITY

Circle your current pain intensity with "0" representing no pain and "10" the most severe pain imaginable.

0 1 2 3 4 5 6 7 8 9 10

_____
Last Name First Name

7a) MEDICATONS:

(Please list your current medications with dosages and circle any medicines that are new since your last visit)

1	**5**
2	**6**
3	**7**
4	**8**

7b) Please list any medications that you have stopped since your last visit and state the reason for stopping.

1
2
3

8) During the past month, how many blocks could you walk? _____ Blocks

9) How long can you sit before you have to stand? _____ minutes _____ hours

10) How long can you stand before you have to sit? _____ minutes _____ hours

11) **PRIOR INJECTIONS OR PROCEDURES**

Name of procedure performed since your last visit_____ None ☐

Did you notice any relief? ☐ No ☐ Yes

If yes, what percent relief did you notice? _____ % For how long? _____

Did you have any side effects from your last procedure? ☐ No ☐ Yes

What was the side effect? _____

_____

Last Name First Name