Follow-up Pain Assessment

Name: ____ Birthdate: ____________ Date: ____________

Circle all that apply regarding your pain:

How would you rate your current pain on a scale of 1-10 (0 for no pain, 10 for worst): ________

How would you rate your average day to day pain on a scale of 1-10 (0 for no pain, 10 for worst): ________

Since your last visit, has the pain gotten: Worse Better Same Other ________________________________

Location of pain: Back Arm Neck Head Leg Other____

Quality of pain: Aching Burning Cramping Dull Numbness Pins & Needles Sharp Shooting Stabbing Stiffness Swelling Throbbing Tingling Other _____________________________________

Does the pain radiate (spread): No Yes: Legs Arms Other _________ Right Left Bilateral

The pain is: Intermittent Constant - **And lasts for:** Minutes Hours Days

What makes the pain better? Rest Pain Meds Ice Heat Lying down Massage Nothing Other________

What makes the pain worse? Bending Head turning Lying down Sitting Standing Twisting Other _____

Which activities does the pain effect: Bathing/Showering Cooking Cleaning Home Exercising Family Activities Hobbies (Which?_________________) Shopping Sleep Social Activities Walking Working Other _________________

What percentage of pain is relieved with pain medication (0-100): ________

Any side effects from the pain medication since last visit? ____

Has any other doctor treated your pain since your last visit? ____________________________________

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Please circle all the symptoms you are recently experiencing, if any:

Constitutional: Changes in appetite Fatigue Fever Sleeping disturbances

Respiratory: Cough Shortness of breath Wheezing

Cardiovascular: Blacking out Fainting Chest pain Irregular heartbeats

Neurologic: Changes in alertness Seizures

Psychiatric: Hallucinations Anxiety Depressed mood Suicidal thoughts

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PLEASE REPORT ANY CHANGES IN MEDICATIONS TO THE PERSON ROOMING YOU

FOR OFFICE USE ONLY: MA Name ______________________

Wt __________ **Ht** __________ **BP** __________ **P** __________ **O2** __________ **CURES** _____ **Contract** _____ **Lab** _____