INNOVATIVE PAIN AND WELLNESS™
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Follow-Up Paperwork

****Please fill out this paperwork in its entirety. DO NOT use "same" for any answers.****

Today's Date:_____ Today's Provider:_____

Your Name:_____ Date of Birth:_____

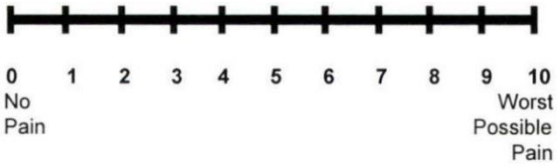
Height:_____ Weight:_____

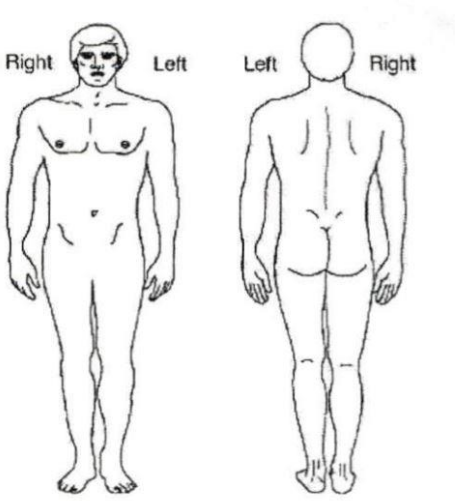
Reason For Today's Visit

☐ Medication Refill ☐ Medication Change ☐ Post-Procedure Assessment

☐ Review Test/Imaging Results ☐ Other:_____

Pain Description





Please rate your pain using a 0 – 10 scale:
_____ Your **pain right now**?
_____Your **worst pain**?
_____Your **least pain**?
_____Your **average pain over the last month**?

Where is your worst area of pain located?
_____

Does this pain radiate? If so, where?
_____

Check all that describe your pain today:

☐ Aching ☐ Spasming
☐ Cramping ☐ Squeezing
☐ Dull ☐ Stabbing/Sharp
☐ Hot/Burning ☐ Throbbing
☐ Numb ☐ Tingling/Pins & Needles
☐ Shock-like ☐ Tiring/Exhausting
☐ Shooting

Pain Frequency

What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐ Mornings ☐ During the day ☐ Evenings ☐ Middle of the night

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Mark all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life ☐ Normal Work ☐ Sleep

☐ General Activity ☐ Recreational Activities ☐ Walking

☐ Mood ☐ Relationship with people ☐ Other:_____

Since your last visit, have you developed any new:

☐ Balance Problems ☐ Bladder Incontinence ☐ Bowel Incontinence ☐ Chills

☐ Difficulty Walking ☐ Fevers ☐ Nausea ☐ Vomiting

☐ Numbness/Tingling – Location:_____

☐ I have not recently developed any of the above conditions.

Changes since your last visit

☐ I have not had any changes since the last office visit

Have you developed any new pain complaints? ☐ Yes ☐ No If yes, where?_____

How has your pain changed? ☐ Increased ☐ Decreased ☐ Same

What additional treatments have you done?

☐ Procedure If so, what procedure(s)?_____

☐ Physical Therapy How many treatments?_____

☐ Chiropractic How many treatments?_____

☐ Medication Which medication(s)?_____

How much relief have you obtained? _____% Which treatment(s)?_____

Current Medications

Please list any changes since your last visit in the medications you are currently taking.

Medication: **Dosage:** **Date:**

_____

_____

_____

Are you taking any blood-thinners or anticoagulants? ☐ Yes ☐ No

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Review of Symptoms

Mark the following symptoms that you currently suffer from.

Constitutional:

- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Easy Bruising
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia
- ☐ Low Sex Drive
- ☐ Night Sweats
- ☐ Weakness
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Loss

Eyes:

- ☐ Recent Visual Changes

Ears/Nose/Throat/Neck:

- ☐ Dental Problems
- ☐ Earaches
- ☐ Hearing Problems
- ☐ Nosebleeds
- ☐ Recurrent Sore Throats
- ☐ Ringing in the Ears
- ☐ Sinus Problems

Cardiovascular:

- ☐ Bleeding Disorder
- ☐ Chest Pain
- ☐ Deep Vein Thrombosis
- ☐ Fainting
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Lightheadedness
- ☐ Swelling in the feet
- ☐ Shortness of Breath During Sleep

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath on Exertion
- ☐ Shortness of Breath at Rest

Gastrointestinal:

- ☐ Abdominal Cramps
- ☐ Acid Reflux
- ☐ Constipation
- ☐ Coffee Grounds Appearance in Vomit
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Hernia
- ☐ Dark and Tarry Stools

Musculoskeletal:

- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Muscle Spasms
- ☐ Neck Pain

Genitourinary/Nephrology:

- ☐ Blood in Urine
- ☐ Decreased Urine Flow/Frequency/Volume
- ☐ Erectile Dysfunction
- ☐ Flank Pain
- ☐ Painful Urination
- ☐ Pelvic Pressure

Neurological:

- ☐ Dizziness
- ☐ Headache
- ☐ Instability when walking
- ☐ Carpal Tunnel Syndrome
- ☐ Numbness/Tingling
- ☐ Seizures

Psychiatric:

- ☐ Depressed Mood
- ☐ Feeling Anxious
- ☐ Stress Problems
- ☐ Suicidal Planning
- ☐ Suicidal Thoughts