WAKE SPINE & PAIN SPECIALISTS

FOLLOW UP VISIT

Patient name: _____ **DOB:** _____ **Today's Date:** _____

Reason for visit: ☐ Medication refill ☐ Medication change ☐ Post-procedure assessment ☐ Review MRI results
Other _____

Please list any new complaints since last visit:
_____

Pain score today: ____ **(0-10)**
Average pain score since last visit**:** _____ **(0-10)**

PAIN: (check one)
☐ Worsened ☐ Improved ☐ Unchanged ☐ Stable

PAIN DESCRIPTION: ☐ none ☐ unchanged
☐ burning ☐ stinging ☐ aching
☐ tender ☐ stabbing ☐ numbness
☐ tingling ☐ spasm ☐ throbbing

How often does the pain occur:
☐ Constant ☐ Several times a day
☐ Less than daily ☐ Occassionally

Is the pain worse at:
☐ morning ☐ day time ☐ evening ☐ night

Does the pain interfere with your sleep?
☐ Yes ☐ No

RECENT INJECTION:
How much relief did you get _____%
How long did the relief last for _____
Brief comments:
_____

REVIEW OF SYSTEMS:
(check all that apply since your last visit)

☐ Fever	☐ Depressed
☐ Weight gain	☐ Anxious
☐ Weight loss	☐ Suicidal thoughts
☐ Diarrhea	☐ Dizziness
☐ Nausea	☐ Difficulty walking
☐ Constipation	☐ Sleepiness
☐ Vision changes	☐ Chest pain
☐ Neck pain	☐ Lightheadedness
☐ Back pain	☐ Shortness of breath
☐ Joint pain	☐ Bowel incontinence
☐ Muscle spasms	☐ Bladder incontinence

PT / TENS / BACK BRACE
(If referred last visit, indicate if it helped)

	Helped minimally	Helped significantly	Did not help
Physical therapy			
TENS			
Back brace			

MEDICATIONS EFFECTS:
☐ Confusion ☐ Sedation ☐ Dizziness ☐ Drowsiness
☐ Constipation ☐ Dry Mouth ☐ Nausea ☐ Vomiting
☐ Weight Gain ☐ Anxiety ☐ Irritability

☐ I do not have any adverse side effects from current medications.
☐ I am stable on my current medication regimen.
☐ My medications help to improve my functioning & quality of life.

OPIATE COMPLIANCE:
☐ Feel addicted to narcotics
☐ Use street drugs
☐ **D**rive when feeling sedated
☐ Not taking medications as prescribed
☐ Use narcotics for anything other than pain relief

Any medication changes ? [ ] NO (include any changes in Rx prescribed here at last visit)		
Medicine & prescribing physician	Dose	How often

Currently taking any blood thinners/anticoagulants? ☐ Yes ☐ No

Medications prescribed by Dr. Mandhare			
Medicine Dose	Did not help Or side effects	Helped minimally	Helped significantly

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Where is the area of your worst pain located? _____

Please list any additional areas of pain: _____

Does it radiate, if so where? _____

☐ Numbness/tingling where _____ ☐ Weakness where _____

Numbness	Weakness	Ache	Pins & Needles	Burning	Radiating pain
NNNN	WWWW	AAAA	PPPP	BBBB	//////////

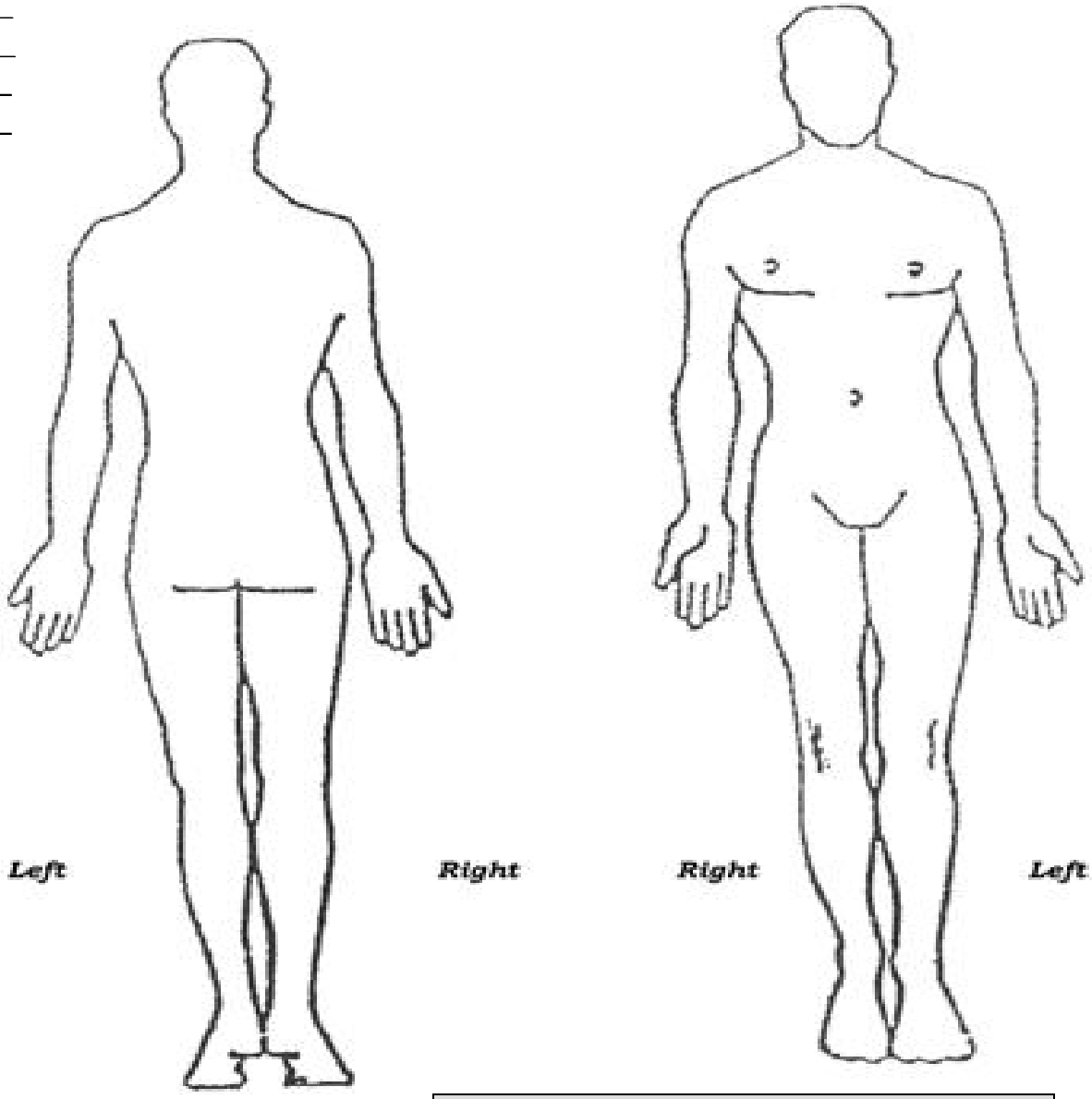
Neck Pain % _____

Arm Pain % _____

Back Pain % _____

Leg Pain % _____

Total: 100%



Patient Signature:

---------- *FOR CLINIC USE* ----------