MD PAIN
SPORT, SPINE, AND PAIN MANAGEMENT

Chronic Pain Management Established Patient Follow-up Form

Name: _____ Age: _____ Sex: ☐ *Male* ☐ *Female* Height: _____ Weight: _____ *lb*

Reason for Today's Visit (Mark all that apply)

☐ Routine follow-up
☐ Imaging review
☐ Medication refill
☐ Test result review
☐ Medication problem or change
☐ Post-procedural assessment
☐ New problem: _____
☐ Other: _____

My CHIEF COMPLAINT is (Mark only ONE)

☐ Headache ☐ Neck pain ☐ Left arm pain
☐ Facial pain ☐ Mid back pain ☐ Right arm pain
☐ Chest wall pain ☐ Low back pain ☐ Left leg pain
☐ Abdominal pain ☐ Buttock pain ☐ Right leg pain
☐ Groin pain ☐ Tailbone pain ☐ Other: _____

Mark any ADDITIONAL pain complaint(s)

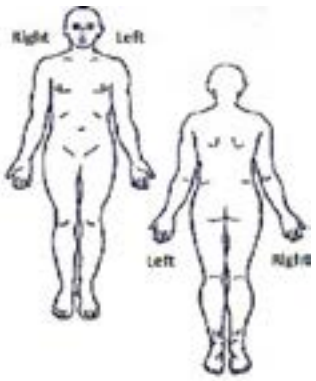
☐ Headache ☐ Neck pain ☐ Left arm pain
☐ Facial pain ☐ Mid back pain ☐ Right arm pain
☐ Chest wall pain ☐ Low back pain ☐ Left leg pain
☐ Abdominal pain ☐ Buttock pain ☐ Right leg pain
☐ Groin pain ☐ Tailbone pain ☐ Other: _____

Please answer ALL of the following questions

1. How severe is your pain right now? _____ (0-10)
2. How severe is your pain when aggravated? _____ (0-10)
3. What is an acceptable pain score goal for you to perform your daily activities? _____ (0-10)
4. Which activities are you no longer able to do because of your pain but would like to be able to do again?

_____

Indicate where your pain is located:



1. **Describe your pain with the following letters**
   Aching = A
   Burning = B
   Cramping = C
   Dull = D
   Numbness = N
   Pins/Needles = P
   Sharp = S
   Throbbing = T
   Muscle spasms = M
2. **Draw arrows where your pain radiates.**

What makes your pain worse?

What makes your pain better?

Since your last visit, have you had any new

☐ Balance problems ☐ Numbness: ☐ arms ☐ legs
☐ Difficulty walking ☐ Tingling: ☐ arms ☐ legs
☐ Bladder Incontinence ☐ Weakness: ☐ arms ☐ legs
☐ Bowel Incontinence ☐ Other:

Does your pain affect your mood, appetite, or sleep and, if yes, which?

Since being treated at MD Pain, how has your pain changed?

Overall pain relief: _____% (0-100%)
Overall functional improvement: _____% (0-100%)
Improvement in quality of life: _____% (0-100%)

How much are your pain medications helping?

Pain relief _____% (0-100%)
Functional improvement _____% (0-100%)
Improved quality of life _____% (0-100%)
☐ I am not taking any prescription pain medications

Are you having any side effects? ☐ Yes ☐ No ☐ N/A
If 'yes', which? _____

Please list any changes to your medications:

_____

If you had a pain injection/procedure since your last visit, how have you responded?

Pain relief _____% (0-100%)
Functional improvement _____% (0-100%)
Duration of benefit _____ (hours, days, weeks, months)
Any side effects? _____
☐ I have not had any procedures since my last visit.

Are you receiving other treatments for your pain?

☐ Yes ☐ No

Physical therapy:	☐ Helpful	☐ Not helpful	☐ N/A
Chiropractic:	☐ Helpful	☐ Not helpful	☐ N/A
Massage:	☐ Helpful	☐ Not helpful	☐ N/A
Acupuncture	☐ Helpful	☐ Not helpful	☐ N/A
TENS Therapy	☐ Helpful	☐ Not helpful	☐ N/A
Bracing/Orthotics	☐ Helpful	☐ Not helpful	☐ N/A
Other:	☐ Helpful	☐ Not helpful	☐ N/A

Since your last visit, have you had any new:

Testing/imaging? ☐ Yes ☐ No If yes, what?
Blood thinners? ☐ Yes ☐ No If yes, which one?
Hospitalizations or surgeries? ☐ Yes ☐ No If yes, what?
Other concerning symptoms or health changes? ☐ Yes ☐ No
If yes, please explain.

Please list any additional information and/or concerns here:

I certify that the above information is accurate and true.

Signature: _____

Today's Date: _____