Follow-up Visit

Physician (Check One): ☐ Letchuman ☐ Majors ☐ Nelson ☐ Mosura

Date: _____ Arrival Time: _____

Name _____ **DOB** _____ **Age** _____

Primary Insurance _____ **Secondary** _____

Work Comp ☐ Yes ☐ No **If Yes: Plan Name and date of injury**_____

Your Current Address _____

Home Phone _____ **Cell Phone** _____

Email _____

Current Work Status (if applicable): ☐ **Full-time** ☐ **Part-time** ☐ **Restricted duty** ☐ **Retired** ☐ **Disabled** ☐ **Never worked**

Marital Status: ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Single**

Tobacco Use: ☐ **Yes** ☐ **No/Never** ☐ **Former User – How many years did you smoke** _____

If Yes, Type ☐ **Cigarette** ☐ **Cigar** ☐ **Pipe** ☐ **Chewing** ☐ **Smokeless** **Daily Use** _____

Alcohol: ☐ **Yes** ☐ **No**

Since your last visit have you developed any new Medical Problems or have you seen any other physicians?

_____

Have you received any new medications from any other doctors? If so, then list below. Also list if you have received any pain medication from any other provider other than Pain Care Consultants

Medication Name	Dose	How you are taking it	Side effects	Prescribing Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Drug Allergies: _____

Are you having any new side effects or problems with the pain medications you are prescribed in this clinic?

Describe your pain: ☐ Dull ☐ Achy ☐ Constant ☐ Stabbing ☐ Burning ☐ Throbbing ☐ Tingling ☐ Other _____

What makes your pain worse: ☐ Walking ☐ Sitting ☐ Standing ☐ Other _____

What makes your pain better: ☐ Sitting ☐ Moving around ☐ Medications ☐ Ice ☐ Heat ☐ Other _____

In the last 4 weeks have you had (Check all that applies):

☐ Episodes of Sadness / Crying

☐ Nausea / Vomiting ☐ Stomach Pain ☐ Bloody-Stools ☐ Constipation

☐ Chest Pain / Bloody-cough / Wheezing ☐ Pain or blood when urinating

☐ Excessive sleepiness during the day ☐ Disturbed sleep at bedtime

Did you have a pain procedure since your last office visit?

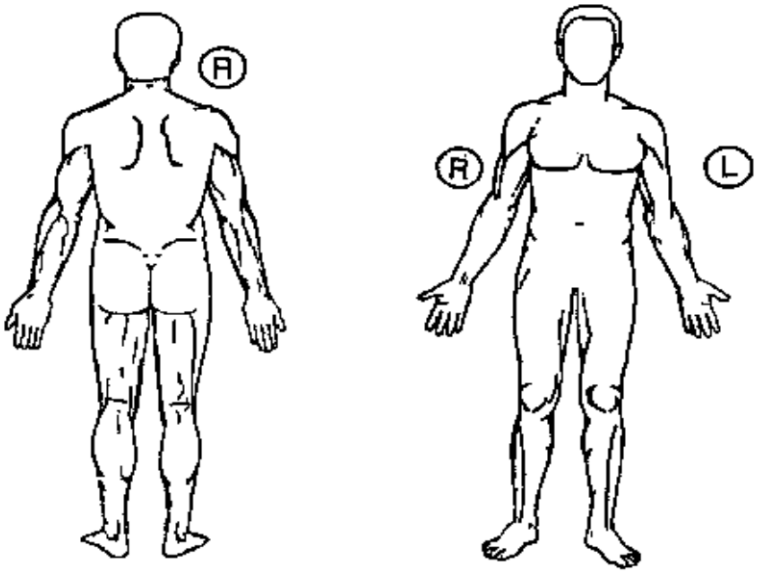
If so, How much pain relief did you have initially (% improvement) _____

How much pain relief do you still have (% improvement) _____

Any complications from the procedure? _____

Have you been to Physical Therapy since your last visit? Is it helping your pain? Please describe.

Mark the parts of your body where you have pain:



Since your last visit is your pain: ☐ Better ☐ Worse ☐ Unchanged

Rate Your Pain while on your <u>current</u> treatment (0 = None, 10= Worst pain imaginable)

Pain Today**:**	0	1	2	3	4	5	6	7	8	9	10
Least pain since last visit:	0	1	2	3	4	5	6	7	8	9	10
Worst pain since last visit:	0	1	2	3	4	5	6	7	8	9	10
Average pain since last visit:	0	1	2	3	4	5	6	7	8	9	10

In the last 24 hours, how much pain relief have your current treatments provided? (0-100%) _____

In the last 24 hours, circle the number which describes how pain has interfered with your:

A: General Activity	0	1	2	3	4	5	6	7	8	9	10
B: Mood	0	1	2	3	4	5	6	7	8	9	10
C: Walking Ability	0	1	2	3	4	5	6	7	8	9	10
D: Normal Work	0	1	2	3	4	5	6	7	8	9	10
E: Relationships with people	0	1	2	3	4	5	6	7	8	9	10
F: Sleep	0	1	2	3	4	5	6	7	8	9	10
G: Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10
	Does not interfere									Completely interferes	

Pharmacy _____ Address _____ Phone _____

Patients receiving pain medications need to read and sign below.

In order to help ensure a safe treatment plan for my pain, I have previously signed a detailed treatment agreement pertaining to pain medications and agree to terms in that agreement. I agree to take my pain medication exactly as directed and specified on my prescription. I agree to receive pain medication only from Pain Care Consultants unless I notify them first of the need for a pain medication from another provider. I agree to keep my pain medication in a safe, secure location protected from theft or inadvertent destruction. I agree to take only medication prescribed to me. I agree never to share or sell my medication to another person. I agree to fully abstain from the use of any illegal substances. I agree to notify Pain Care Consultants and seek additional treatment if I ever feel I am becoming addicted to my medication. I understand these guidelines are for my safety and well-being.

Patient Signature: _____ Date: _____

<u>Physicians Notes</u>

Vital Signs: Temp: _____ HR: _____ BP: _____ Pulse Ox: _____ Height: _____ Weight: _____

☐ **UDS _____** **Procedure: _____**

☐ **Referred To _____** **Reason: _____**

Plan: _____ **Med Check: ☐ One Month ☐ Two Month**

_____ **F/U: 1 2 3 4 5 6 12**

_____ ☐ **Days** ☐ **Weeks** ☐ **Months**