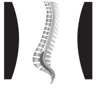


THE SPINE & PAIN CENTER

501 Cetronia Road, Suite 125
Allentown, PA 18104

830 Ostrum Street
Bethlehem, PA 18015

3 Parkinsons Road
East Stroudsburg, PA 18301

1700 St. Luke's Boulevard, Suite 200
Easton, PA 18045

755 Memorial Parkway, Suite 201
Phillipsburg, NJ 08865

120 Pine Street
Tamaqua, PA 18252

1534 Park Avenue, Suite 310
Quakertown, PA 18951

Phone: (484) 526-7246
Fax: (484) 893-7098

FOLLOW UP VISIT

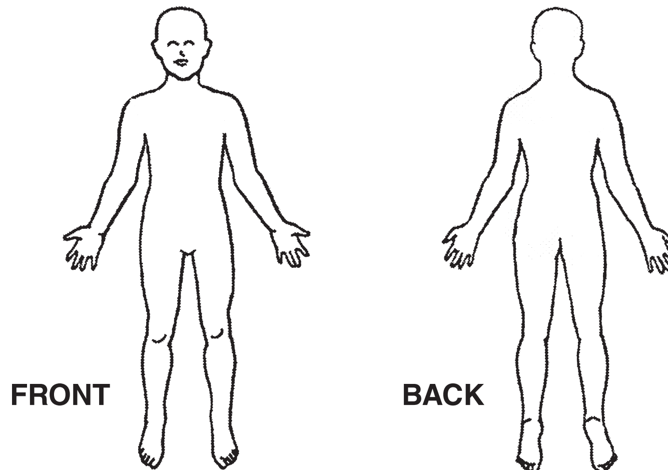
Name: ______________________________ DOB: ______________

1. Since last physician visit, are your symptoms: ☐ Better ☐ Worse ☐ Same Pain score: _______/ 10

2. If you had an injection since last visit, was it helpful? ☐ N/A ☐ No ☐ Yes
   If Yes, for ________ days / weeks / months / ongoing

3. **Describe Your Pain:** *(Please check all that apply)*
   My pain is worse in: ☐ Morning ☐ Evening ☐ Night
   My pain is: ☐ Constant ☐ Intermittent ☐ Occasional
   The quality of my pain is: ☐ Burning ☐ Dull-Aching ☐ Sharp ☐ Throbbing ☐ Cramping ☐ Pressure-like
   ☐ Shooting ☐ Numbness ☐ Pins & Needles ☐ Other *(Describe)*: ______________________

PLEASE INDICATE LOCATION OF PAIN ON DIAGRAM BELOW (Mark location with an X)



4. If you are not being prescribed pain medicine from this office, please skip to Question #5.

   Is the amount of pain relief you are now obtaining from your current pain relievers enough to make a real difference in your life? ☐ **Yes** ☐ **No**

   What percentage of your pain has been relieved with your current pain treatment? ______________

   Please list any side effects that you feel may have been caused by your pain medicine:

Side Effects	*When*	*Doctor's Instructions*	*What you did about them*

PLEASE COMPLETE THE BACK PORTION OF THIS SHEET

5. Circle the numbers below that best describe how pain has interfered with your daily functioning this past week.

Family / Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).
0 = No disability 0 1 2 3 4 5 6 7 8 9 10 10 = Worst disability

Recreation: This category include hobbles, sports and other similiar leisure time activities.
0 = No disability 0 1 2 3 4 5 6 7 8 9 10 10 = Worst disability

Social Activity: This category refers to activities that involve participation with friends and acquaintance other than family members. It includes parties, theater, concerts, dining out, and social functions.
0 = No disability 0 1 2 3 4 5 6 7 8 9 10 10 = Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.
0 = No disability 0 1 2 3 4 5 6 7 8 9 10 10 = Worst disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
0 = No disability 0 1 2 3 4 5 6 7 8 9 10 10 = Worst disability

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.
0 = No disability 0 1 2 3 4 5 6 7 8 9 10 10 = Worst disability

6. **Has there been any change in medications/medical/surgical history:** *(Please list the changes)*

______________________ ______________________
______________________ ______________________
______________________ ______________________

7. **Review of Systems:** *(Please check all that apply)*

- ☐ Difficulty Walking
- ☐ Decreased Range of Motion
- ☐ Paralysis or Muscle Weakness
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Joint Stiffness
- ☐ Seizures or Convulsions
- ☐ Swelling *(Specify)*: ______________________
- ☐ Pain in Extremity *(Specify)*: ______________________
- ☐ Memory Loss
- ☐ Rash
- ☐ Shortness of Breath
- ☐ Diarrhea

8. Patient Signature: ______________________ Date: __________ Time: __________

☐ All other review of systems negative

ROS and full History reviewed by: ______________________ Date: __________ Time: __________
SIGNATURE OF PROVIDER