St Luke's
Spine & Pain Associates

Allentown
501 Cetronia Road, Suite 125
Allentown, PA 18104
Fax: 833-219-0472

Anderson
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Fax: 833-219-0473

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Fax: 833-219-0471

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Lehighton
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Orwigsburg
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Quakertown
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Tamaqua
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Fax: 833-219-6192

Warren, NJ
Bone and Joint
755 Memoriall Pkwy., Bldg. 201
Phillipsburg, NJ 08865
Fax: 833-219-0476

Phone: 484-526-7246

FOLLOW UP VISIT

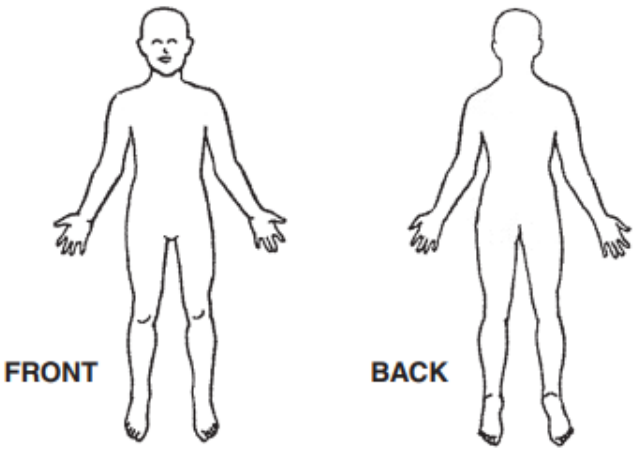
Name:_____
DOB:_____

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.

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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	Action taken

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 activity 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 1 2 3 4 5 6 7 8 9 10= Worst disability

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

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

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Life-Support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.
0=No disability 1 2 3 4 5 6 7 8 9 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	❑Joint Stiffness
❑Decreased Range of Motion	❑Seizures or Convulsions
❑Paralysis or Muscle Weakness	❑Chest Pain
❑Swelling (specify):	❑Memory Loss
❑Pain in Extremity (specify):	❑Dizziness
❑Nausea	❑Rash
❑Vomiting	❑Shortness of Breath
❑Constipation	❑Diarrhea

8. Patient Signature:

_____

Date: _____ Time: _____

❑All other review of systems negative

ROS and full History reviewed by:

_____

Date: _____ Time: _____