PAIN MANAGEMENT E H R FOLLOW-UP INTAKE FORM

Patient Name: ____ **Date:** ______________

What doctor are you seeing today? Dr.____________________________________

Are you here for a routine follow up appointment? □Yes □No **or** **Post Injection** □Yes □No

Where is your pain located today: *check all that apply* □ Low Back □ Neck □ Right Leg □ Left Leg □ Right Arm □ Left Arm □ Mid-Back □Upper Back □ Buttock □ Head OTHER______________

Please rate your pain over the past 24 hours. (today) No pain 0 1 2 3 4 5 6 7 8 9 10 most severe
please circle all that apply

What words describe your pain? (Quality) *check all that apply*
□ burning □ cramping □ crushing □ cutting □ diffuse □ dull ache □ electric □ flickering □ gnawing □ itching

□ localized □ nagging □ pinching □ pressing □ pricking □ pulsing □ radiating □ sharp □ shooting □ squeezing

□ stabbing □ stinging □ throbbing □ tightness □ tingling

Where does your pain radiate to? □ Right Leg/Above Knee □Right Leg/Below Knee □ Left Leg/Above Knee

□ Left Leg/Below knee □ Right Arm/Above Elbow □ Right Arm/Below Elbow □ Left Arm/Below Elbow

□ Left Arm/Above Elbow □ Upper Back □ Head □ Buttock Other ________________

Which make your symptoms/pain better? □ Rest □ Meds □ Bending/leaning forward □ Extending Back □ Ice □ Heat

□ Sitting □Standing □Walking/Activity □ Massage □ Physical Therapy □ Chiropractor □ Injection Therapy

□ Acupuncture □Yoga □ Nothing Helps □ Other ____________

What makes your symptoms/pain worse? □ Stretching □ Sitting □ Standing □ Twisting □ Walking □ Bending Forward

□ Extending Back □ Warmth □ Cold □Lifting □ Exercise □ Stairs □ Lying in bed □ Coughing

□ Physical Therapy □ Other ____________

Do you have any Pain Medication related side effects? □Yes □No
Do medications cause any of the following? □ Drowsiness □Constipation □ Nausea □ Itchiness OTHER____________

Have you had any recent surgeries or procedures or change in your health status since your last visit? If yes, Please list below:

____

Current Work Status: Please check off your current work status if you are a Workers Compensation Patient.
□ Regular Duty □ Light Duty □ Not working due to this injury □ Disabled □ Retired □ Student

If this is a Workers Compensation injury; Please list injury date: ____________

If this is a No Fault injury; Please list date of accident: __________

Are you currently taking any medications for the pain? □ Yes □ No
If yes, which medications? **Please circle the medications that need to be refilled today**

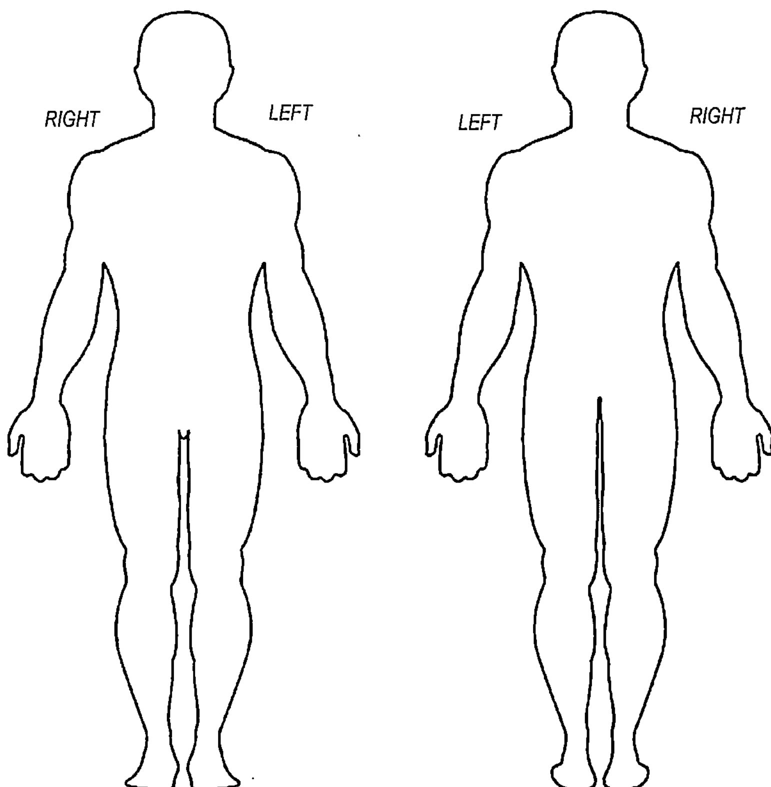
______________/__________________/________________/__________________

LAST NAME	FIRST NAME	APPOINTMENT DATE	What MD are you seeing today?

REVIEW OF SYSTEMS **Have you had any problems related to the following systems?** ***Circle all that apply***

If "No" mark NONE / "Yes" write Details or Comments below

Constitutional Systems	Chills	Fever	Headache	None
Eyes	Blurred	Double Vision	Vision Change	None
Ear/Nose/Throat	Earache	Sore Throat	Sinus Congestion	None
Cardiovascular	Chest Pain	Shortness of Breath	Palpations	None
Respiratory	Chronic Cough	Wheezes	Asthma	None
Gastrointestinal	Abdominal Pain	Nausea	Bowel Habit Changes	None
Genitourinary	Frequent Urination	Urine Retention	Kidney Problems	None
Musculoskeletal	Neck Pain	Back Pain	Joint Pain	None
Skin	Rash	Skin Discolor	Persistent Itch	None
Neurologic	Stroke	Weakness	Vertigo	None
Psychiatric	Anxiety	Depression	Sleep Disorders	None
Endocrine	Thirst Increase	Sweats	Thyroid Disease	None
Hematologic/Lymphatic	Swollen Glands	Blood Clotting Problem	Anemia	None
Allergic/Immunologic	Hay Fever			None



Please use the appropriate symbols to describe your symptoms and mark the location as accurately as possible on the body drawing to the left:

- **ACHING - AAAAA**
- **STABBING - //////**
- **TINGLING - ___________**
- **BURNING - XXXXX**
- **NUMBNESS - 00000**