Follow-up visit

Name: _____
Date: _____

1. Please list your allergies:

_____

2. Since your last visit to the Pain Clinic, have you experienced CHANGES IN YOUR GENERAL HEALTH? Please describe any changes below:

_____

3. Have you had and other physician visits or procedures since your last visit to the Pain Clinic?

_____

4. Have you received any new medication for other conditions since your last visit?
Please list:

_____

5. Since the last visit, describe your level of pain over the last week:
   Circle one: improved worse no change
6. How would you describe your pain? Circle those that apply:
   Sharp aching burning stabbing dull
7. What relieves your pain? Circle those that apply:
   Rest ice heat medications exercise sitting
other_____
8. What makes your pain worse? Circle those that apply.
   Standing walking sitting stress
other_____
9. If you had a procedure on your last visit, has your pain improved? **Y**es or **N**o (circle one)
   a. If so, how much? _____%
   b. How long did the relief last? _____(circle: days weeks months)
   c. How much relief do you still have? _____%
10. Any recent stressors?

_____

11. Please list any **NEW** medications, doses, and any side effects you are experiencing, since your last visit: (Note: If all
medication information is the same since your last visit, write **NO CHANGES**)

Name	Dose	Times taken per day	Prescribing MD	Side Effects

12. Describe your exercise routine or current physical therapy regimen:

_____

13. What would you like to focus on during this visit?

_____

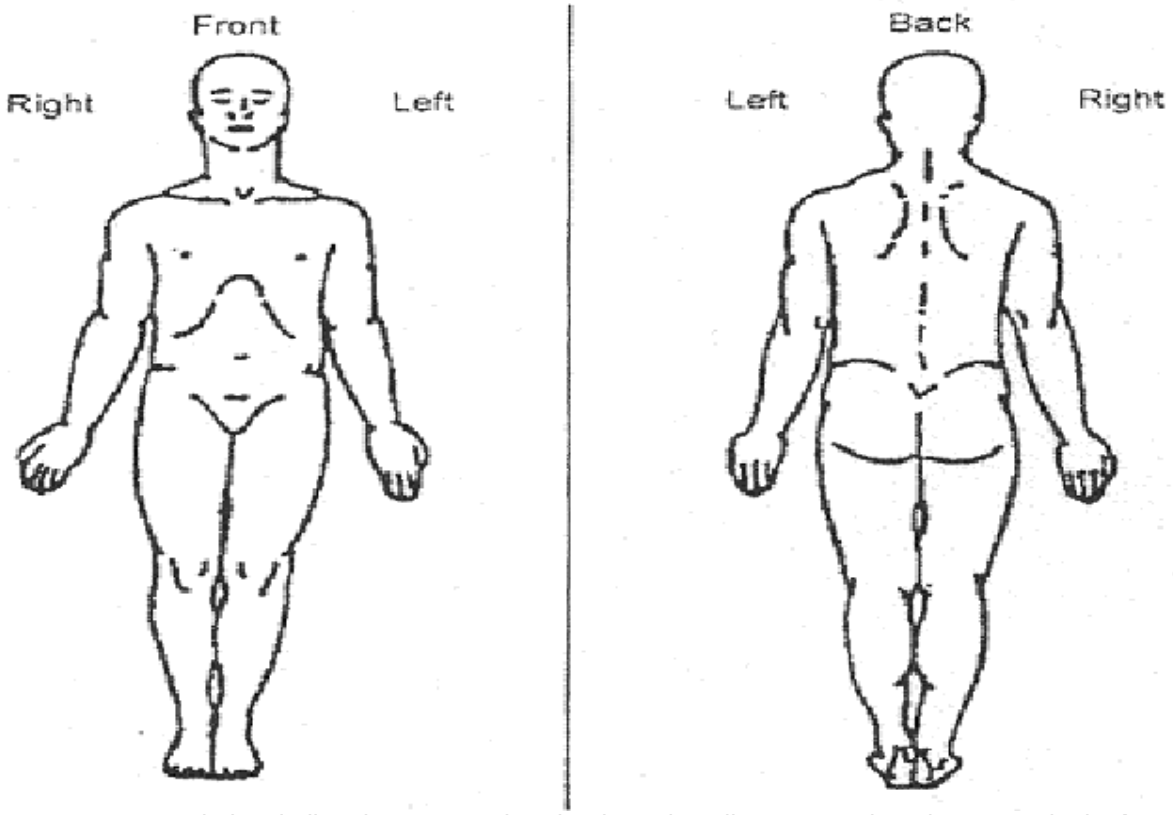
Brief Pain Inventory: Short Form

1. Name: _____ Todays Date: ____/_____/_____

2. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these everyday kinds of pain today?

Yes No

3. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



4. Please rate your pain by circling the one number that best describes your pain at its **worst** in the **last week**

0	1	2	3	4	5	6	7	8	9	10
no pain								Pain as bad as imaginable		

5. Please rate your pain by circling the one number that best describes your pain at its **least** in the **last week**

0	1	2	3	4	5	6	7	8	9	10
no pain								Pain as bad as imaginable		

6. Please rate your pain by circling the one number that best describes your pain on the **average**

0	1	2	3	4	5	6	7	8	9	10
no pain								Pain as bad as imaginable		

7. Please rate your pain by circling the one number that that tells how much pain you have **right now**

0	1	2	3	4	5	6	7	8	9	10
no pain									Pain as bad as imaginable	

8. What kinds of things make your pain feel better? (For example: heat, medicine, rest, sitting, physical therapy)

_____

9. In the **last week**, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows **how much relief** you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
no relief									complete relief	

10. Circle the number that describes how, during the **past week, pain has interfered with your:**

A. General Activity:

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely interferes	

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely interferes	

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely interferes	

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely interferes	

E. relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely interferes	

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely interferes	

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere									Completely interferes	