Follow Up Questionnaire

TELL US HOW YOU HAVE BEEN FEELING (CHIEF COMPLAINT)

What would you like to focus on or talk about during this clinic visit?

__________________________________________________________________________________________

__________________________________________________________________________________________

DESCRIBE YOUR RECENT PAIN FOR US (HISTORY OF PRESENT ILLNESS)

Please describe your recent pain problem in your own words (what you feel, when, etc.):

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Please rate the overall amount of pain you are experiencing today by circling a number between 0 and 10, with 0 being no pain and 10 being the worst pain imaginable:

0  1  2  3  4  5  6  7  8  9  10

Please rate the worst amount of pain you have experienced in the last 24 hours:

0  1  2  3  4  5  6  7  8  9  10

Please rate the least amount of pain you have experienced in the last 24 hours:

0  1  2  3  4  5  6  7  8  9  10

Check the boxes that describe the pain you are having right now:

☐ Constant  ☐ Intermittent  ☐ Deep  ☐ Dull  ☐ Sharp
☐ Pulsing  ☐ Stiffness  ☐ Aching  ☐ Shooting
☐ Tender  ☐ Pressure  ☐ Cramping  ☐ Burning
☐ Throbbing  ☐ Stabbing  ☐ Pressing  ☐ Pulling
☐ Like a tight band  ☐ Tingling  ☐ Numbness
☐ Electric Shock
Mark all the area(s) of your body where you feel your pain and describe the type of pain you experience for each area (for example: numbness, pins & needles, burning, aching, and/or stabbing). Please include all of the affected areas of your body:

<table>
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Have you experienced any new pain symptoms since your last visit? ☐ Yes ☐ No If yes, please describe:

__________________________________________________________________________________________
__________________________________________________________________________________________

What has made your pain better since your last visit?
__________________________________________________________________________________________
__________________________________________________________________________________________

What has made your pain worse since your last visit?
__________________________________________________________________________________________
__________________________________________________________________________________________

Has your sleep pattern changed since your last visit? ☐ Yes ☐ No If yes, please describe:
__________________________________________________________________________________________
A page of a document containing multiple-choice questions and a space for writing in responses. The questions and responses are as follows:

**Do you often:**
- Sleep soundly
- Have trouble falling asleep
- Wake up in the middle of the night
- Take sleeping medications
- Wake up feeling well rested
- Feel tired much of the time
- Take naps during the day
- Snore when you are asleep

How many hours do you sleep on average per night? ________________

How would you describe your recent emotional health (check any that applies to you)?
- Happy/cheerful
- Optimistic
- Anxious
- Worried
- Angry
- Depressed
- Suicidal
- Compulsive
- Uninterested
- Hopeless
- Frustrated
- Panicked
- Other: ________________________________

Are you pregnant?: Yes No Not possible Date of last menstrual period: ________________

**TELL US ABOUT YOUR EVERYDAY FUNCTION**

If your pain was adequately controlled, what one activity would you like to do?

________________________________________________________________________________________
________________________________________________________________________________________

What other parts of your life can you not normally do because of your present pain?

________________________________________________________________________________________
________________________________________________________________________________________

**TELL US ABOUT YOUR LIFE (SOCIAL HISTORY)**

Have you been off work since your last clinic visit because of your pain? Yes No

If yes, how many times and for how long?

________________________________________________________________________________________
________________________________________________________________________________________

If you have not been working outside the home, how have you been spending your day?

________________________________________________________________________________________
________________________________________________________________________________________
LET US KNOW ABOUT ANY RECENT SYMPTOMS

Have you noticed any change in your weight or appetite since your last visit? ☐ Yes ☐ No

Have you experienced any nausea or vomiting since your last visit? ☐ Yes ☐ No

Have you experienced any constipation since your last visit? ☐ Yes ☐ No

Have you had any fever or chills this past week? ☐ Yes ☐ No

Have you had any numbness or weakness this past week? ☐ Yes ☐ No

If yes, where? ____________________________________________________________

TELL US ABOUT YOUR MEDICATIONS AND PAIN TREATMENT

**MEDICATIONS:** Please review with the nurse or medical assistant all the medications you are currently taking, with their doses and how often you take them per day. Please include "over the counter" drugs, birth control pills, and vitamins/supplements/herbals, and any medications you use only "as needed" rather than daily.

**ALLERGIES:** Please review with the nurse any medications you cannot take because of allergies or other problems (side effects). Please tell us what reaction you had to each drug.

Which of your **current pain medications** do you feel are helping you?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Which of your **current pain medications** do you feel are **not** helping you or causing troubling side effects?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________