Banner Health®

PAIN CLINIC FOLLOW-UP EVALUATION

PATIENT NAME: _____ DOB: _____/_____/_____

PRIMARY CARE PHYSICIAN NAME: _____

The following questions relate to your general health. The details of this form will only be reviewed by your physician and nurse.

Preferred Pharmacy: (name and location) _____

Any changes in Chronic Medical Problems: ❑ No changes, no additions

1. _____
2. _____
3. _____
4. _____

Any changes to Medications - Type or dose: ❑ No changes since last visit

1. _____ Dosage: _____ # of Times a day _____
Reason for medication: _____
2. _____ Dosage: _____ # of Times a day _____
Reason for medication: _____
3. _____ Dosage: _____ # of Times a day _____
Reason for medication: _____

ALLERGIES: ❑ No known allergies

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Any new issues since last visit:

1. _____
2. _____
3. _____
4. _____

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0164
(05/2017)

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To better provide you with optimum medical care and for better tailoring your medical management, please tell us how you are doing by answering the following questions.

1. What is your pain level today on a scale from 0 (no pain) to 10 (worst pain you have ever experienced)?

0 1 2 3 4 5 6 7 8 9 10

2. By what percentage has your pain improved, *IN THE AREA WE TREATED,* since your last visit in regards to the following? (0 = no change, 100 = complete relief)

Pain intensity	0	20	40	60	80	100
Pain frequency	0	20	40	60	80	100
Duration of pain episodes	0	20	40	60	80	100
Falling asleep	0	20	40	60	80	100
Staying asleep	0	20	40	60	80	100
Ability to work	0	20	40	60	80	100
Ability to exercise	0	20	40	60	80	100
Performing chores	0	20	40	60	80	100

3. Has any of the following changed since your last visit? (Please circle your answer.)

Weight change	Ankle swelling	Diarrhea	Lumps	Tension
Weakness	Cough	Bowel incontinence	Itching	Depression
Fatigue	Sputum	Bloody stool	Hair changes	Anxiety
Fever	Coughing up blood	Pain with urination	Nail changes	Heat
Hearing loss	Difficulty breathing	Bladder incontinence	Headache	Cold intolerance
Nasal congestion	Wheezing	Urgency	Weakness	Sweating
Dizziness	Heartburn	Blood in urine	Numbness	Thirst
Sore throat	Nausea	Joint pain	Seizures	Hunger
Shortness of breath	Vomiting	Stiffness	Blackouts	Bruising
Chest pain	Abdominal pain	Neck or back pain	Memory loss	Bleeding
Palpitations	Constipation	Rash	Nervousness	Ringing in ears

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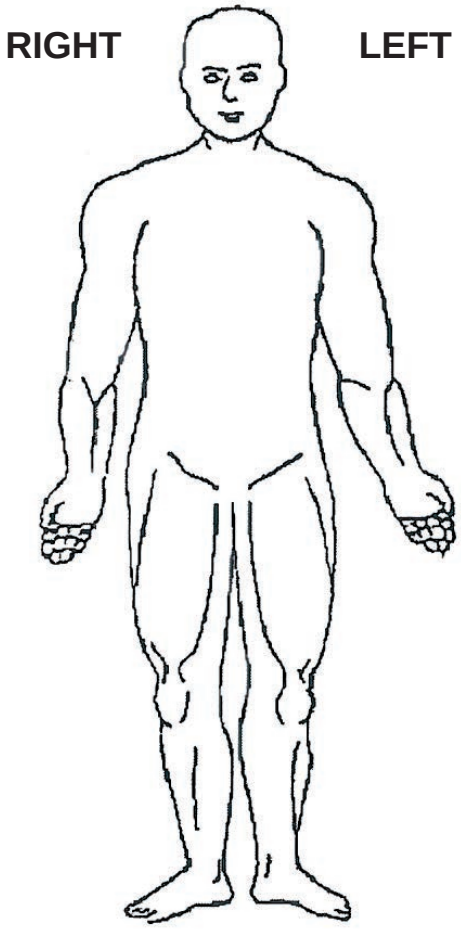
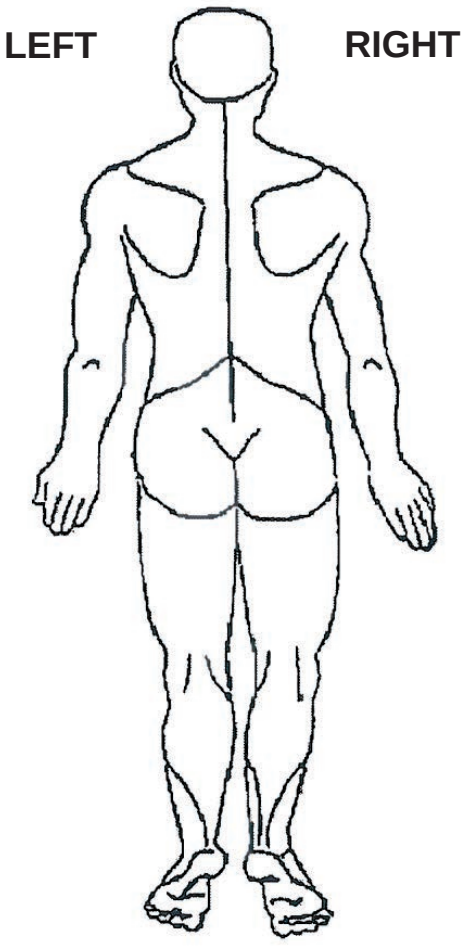
Where is your pain located?

Please shade the areas of your pain in the diagrams below.





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