

FOLLOW-UP WORKSHEET

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: None _____

Date: _____

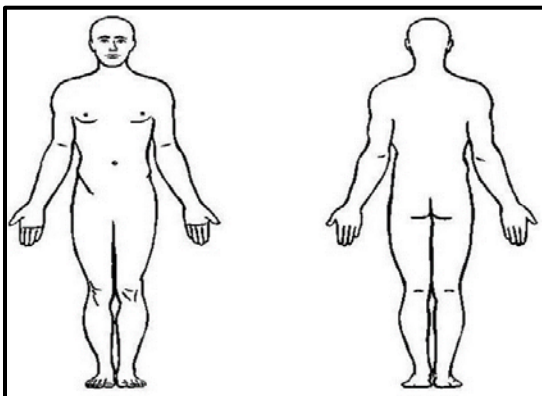
PATIENT HISTORY

If you have been in a MOTOR VEHICLE ACCIDENT please alert the front desk for possible additional information required

1. What is your main pain complaint? _____
2. Is your pain related to a work accident or motor vehicle accident? YES, when? _____ NO
3. Have you had a new injury since last office visit? No Yes, if yes, please explain: _____
4. How would you describe your pain? Sharp Achy Burning Shooting Constant Intermittent _____
5. What increases your pain? Walking Bending Standing Sitting Weather Laying Down _____
6. What decreases your pain? Walking Bending Meds Sitting Laying Down _____
7. Injection on last visit? YES NO If yes, % of improvement: _____
8. Check what you are currently doing? Stretching Chiropractic Care Physical Therapy Massage Other: _____
9. New X-Rays/MRI since last visit? YES NO If yes, where? _____
10. Do you smoke? YES NO If yes, how many packs per day?: _____ How many years?: _____
11. Do you drink? YES NO If yes, how many drinks per day?: _____
12. Are you currently working? YES NO If yes, where? If no, why? _____
13. Are you currently on disability? YES NO If yes, what are you on disability for? _____
14. How would you rate your Pain (Scale of 0-10: 0 = No Pain, 6= Hard to Ignore, 10= Worst Pain Possible)?
Rate your pain now: _____ Rate your pain at its Best: _____ Rate your pain at its Worst: _____
15. Pain relief with medications? YES NO Improved function with Meds? YES NO
Side Effects? YES NO Sedation? YES NO Insomnia? YES NO Constipation? YES NO
16. What Medications do you receive from our Pain Management Physicians? None I need refills without changes I need changes:

17. What medications do you receive from other Physicians? None Blood Thinners BP Meds Diabetic Meds Anxiety Meds
 Sleeping Meds PainMeds OTHER: _____
18. Have you had PT or Chiropractic care in the last 12 months? NO YES If yes, what/when _____
19. Have you had a back brace or tens unit in the last 2 years? NO YES If yes, what/when _____
20. Have you had imaging studies in the last 2 years? NO YES If yes, when/where _____
21. Review of systems: Have you had any new medical diagnosis or symptoms since your last office visit? NO YES I have had the following: _____

Mark Below Where You Hurt



OFFICE STAFF USE ONLY

TRIAGE MA REVIEW UDT schedule reviewed (Red Flag if Needed)

Imaging / PT / Chiro / Tens (Green Flag if Needed)

Reviewed Medications in EHR with patient?

Verified Pharmacy? Rx Printed

Documented blood thinners (flowsheet)?

Verified Allergies?

PATIENT INSTRUCTIONS: Diet Exercise

CARE PLAN: Consent HEP Med Assessment

PROVIDER: Med Discussion Injection Therapy Procedure Indications Urine Med Manag

Rehab/Wellness Brace

OTHER: TPI Toradol Decadron _____

DIAGNOSIS

Same New Stable

Declined Improved

99213 99214 25
