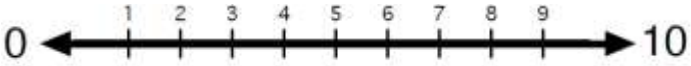
New Jersey Pain Consultants Follow-up Visit Intake Paperwork

Please complete all sections of this form, **even if nothing has changed** since your last visit.

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Height: _____ Weight: _____

Pain Description



Please rate your pain using a 0 – 10 scale:

_____ Your pain **right now**?

_____ Your **worst pain**?

_____ Your **least pain**?

_____ Your **average pain over the last month**?

Where is your worst area of pain located?

_____

Does this pain radiate? If so, where?

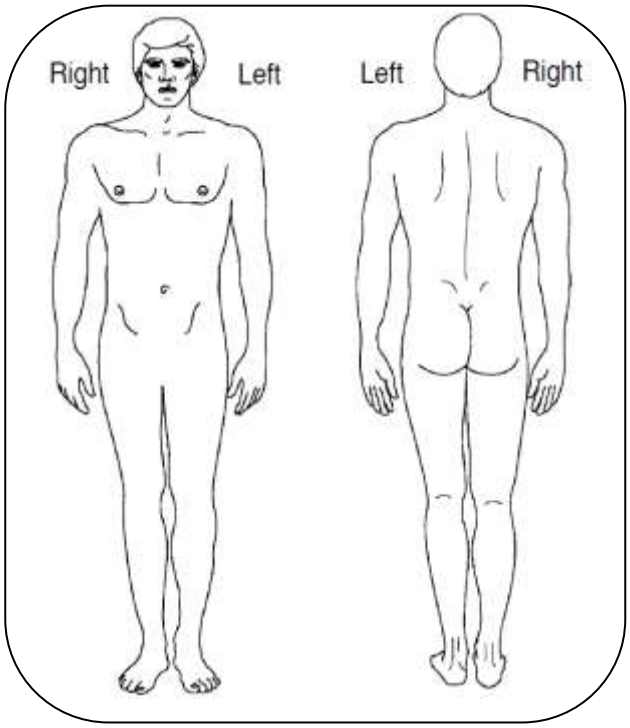
_____

Check all that describe your pain:

❑ Constant	❑ Intermittent	❑ Throbbing
❑ Aching	❑ Shooting	❑ Cramping
❑ Spasming	❑ Dull	❑ Squeezing
❑ Tingling	❑ Burning	❑ Numb
❑ Exhausting	❑ Stabbing/Sharp	❑ Electrical

Mark your pain on the drawing with the following letters that best describe your symptoms:

"**N**" = numbness "**P**" = pins and needles
"A" = aching "**S**" = stabbing "**B**" = burning



Aggravating/Relieving Factors

Mark what makes your pain worse

❑ Sitting ❑ lying down ❑ walking ❑ standing ❑ sneezing ❑ coughing ❑ yardwork ❑ stairs
❑ housework ❑ position changes ❑ working ❑ driving ❑ weather changes ❑ physical recreation

Mark what makes your pain better

❑ Sitting ❑ lying down ❑ standing ❑ heat ❑ ice ❑ medication ❑ TENS ❑ Acupuncture
❑ rest ❑ injections ❑ biofeedback ❑ walking ❑ relaxation exercises ❑ physical therapy

New Problem since last visit? ❑ No ❑ Yes : _____

Circle the number that describes how in the past 24 hours the pain has interfered with the activities

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work (home/job)	0	1	2	3	4	5	6	7	8	9	10
Relations with other people	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of life	0	1	2	3	4	5	6	7	8	9	10

Medications

To what extent are the medications improving your quality of life or ability to get through the day?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What activities do the medications allow you to do that you could not do without the medications?

_____

_____

❑ The medications **do not** allow me to increase my function.

❑ I am stable on my current medication regimen.

❑ My medications help to improve my functioning and quality of life.

Mark the following medication side-effects you are experiencing, if any:

❑ Confusion ❑ Constipation ❑ Dizziness ❑ Drowsiness
❑ Dry Mouth ❑ Nausea ❑ Vomiting ❑ Weight Gain ❑ NONE

Are you taking your medications exactly as prescribed? ❑ YES ❑ NO

Are you receiving any pain medications from any other physician (including dentists, or ER physicians)?

❑ YES ❑ NO If yes, please explain: _____

Are you currently taking any blood-thinners or anticoagulants? ❑ No ❑ Yes _____

Social History

Are you currently working? ❑ YES ❑ NO Occupation: _____

Do you have an exercise program you do at home?❑ YES ❑NO Describe: _____

Do you use alcohol? ❑ NO❑ YES How much?_____ How often? _____

Have you ever felt you should cut down on your drinking? ❑ NO ❑ YES

Have people annoyed you by criticizing your drinking? ❑ NO❑ YES

Have you ever felt bad or guilty about your drinking? ❑ NO ❑ YES

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

❑ NO ❑ YES

Do you smoke? ❑ NO ❑ YES #_____ packs per day ❑ FORMER/Date quit_____

Mark the following symptoms that you currently suffer from.

Constitutional:
- ❑ Weight Loss
- ❑ Chills
- ❑ Night Sweats
- ❑ Excessive Sweating
- ❑ Fatigue
- ❑ Fevers

Head :
- ❑ Glasses/contacts
- ❑ Dry Mouth
- ❑ Ringing in the Ears
- ❑ Visual Changes
- ❑ Hoarseness
- ❑ Sinus problems
- ❑ Hearing Loss

Cardiovascular:
- ❑ Chest Pain
- ❑ Swollen Feet
- ❑ Palpitations
- ❑ Fainting
- ❑ Lightheadedness
- ❑ Short of breath

Respiratory:
- ❑ Cough
- ❑ Wheezing
- ❑ Asthma
- ❑ Sleep Apnea
- ❑ CPAP
- ❑ Short of Breath at Rest

Gastrointestinal:
- ❑ Abdominal Pain
- ❑ Acid Reflux
- ❑ Constipation
- ❑ Nausea
- ❑ Diarrhea
- ❑ Vomiting
- ❑ Bloating
- ❑ Laxative use
- ❑ Loss of bowel control

Genitourinary:
- ❑ Loss of Urinary Control
- ❑ Urinary Frequency
- ❑ Urinary retention
- ❑ Erectile dysfunction
- ❑ Self-catheterize
- ❑ Painful Urination
- ❑ Urinary Dribbling

Musculoskeletal:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Muscle Spasms
- ❑ Muscle Stiffness
- ❑ Neck Pain

Neurological:
- ❑ Dizziness
- ❑ Headaches
- ❑ Numbness_____
- ❑ Seizures
- ❑ Weakness
- ❑ Tremors
- ❑ Tingling _____

Skin:
- ❑ Rashes
- ❑ Itching
- ❑ Wound
- ❑ Infection
- ❑ Pressure Ulcer

Endocrine:
- ❑ Low Sex Drive
- ❑ hot flashes
- ❑ Hair loss
- ❑ Always hot
- ❑ Always cold
- ❑ Always Thirsty

Blood:
- ❑ Bleeding Disorder
- ❑ Easy Bleeding
- ❑ Anemia
- ❑ Easy Bruising
- ❑ Swollen Nodes
- ❑ Swollen Feet
- ❑ Edema

Immune System:
- ❑ Steroid Use
- ❑ Chemotherapy
- ❑ AIDS/HIV

Psychiatric:
- ❑ Depressed Mood
- ❑ Feeling Anxious
- ❑ Mood Swings
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning
- ❑ Insomnia
- ❑ Nightmare

Procedure Followup

Name_____ Date_____

What procedure are you here to follow up for?

❑ Epidural Steroid Injection ❑ SI Joint Injection

❑ Facet Injection ❑ Radiofrequency Ablation

❑ Joint Injection ❑ Spinal Cord Simulator Trial

❑ Nerve Block ❑ Trigger Point Injection

❑ Unknown ❑ Other: _____

How much pain relief did you obtain for your procedure?

❑ None ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

How long did the relief last? _____

What percentage improvement do you have today?

❑ None ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Did you tolerate the procedure well?

❑ Yes ❑ No: Please explain

_____

_____