PATIENT NAME _____ TODAY'S DATE_____

Primary Care Physician _____ Referring Physician_____

Occupation _____ Name of Employer_____

PHARMACY & ADDRESS _____

PHARMACY PHONE # _____

CURRENT MEDICATION

MEDICATION AND DOSE DIRECTIONS DATE STARTED

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

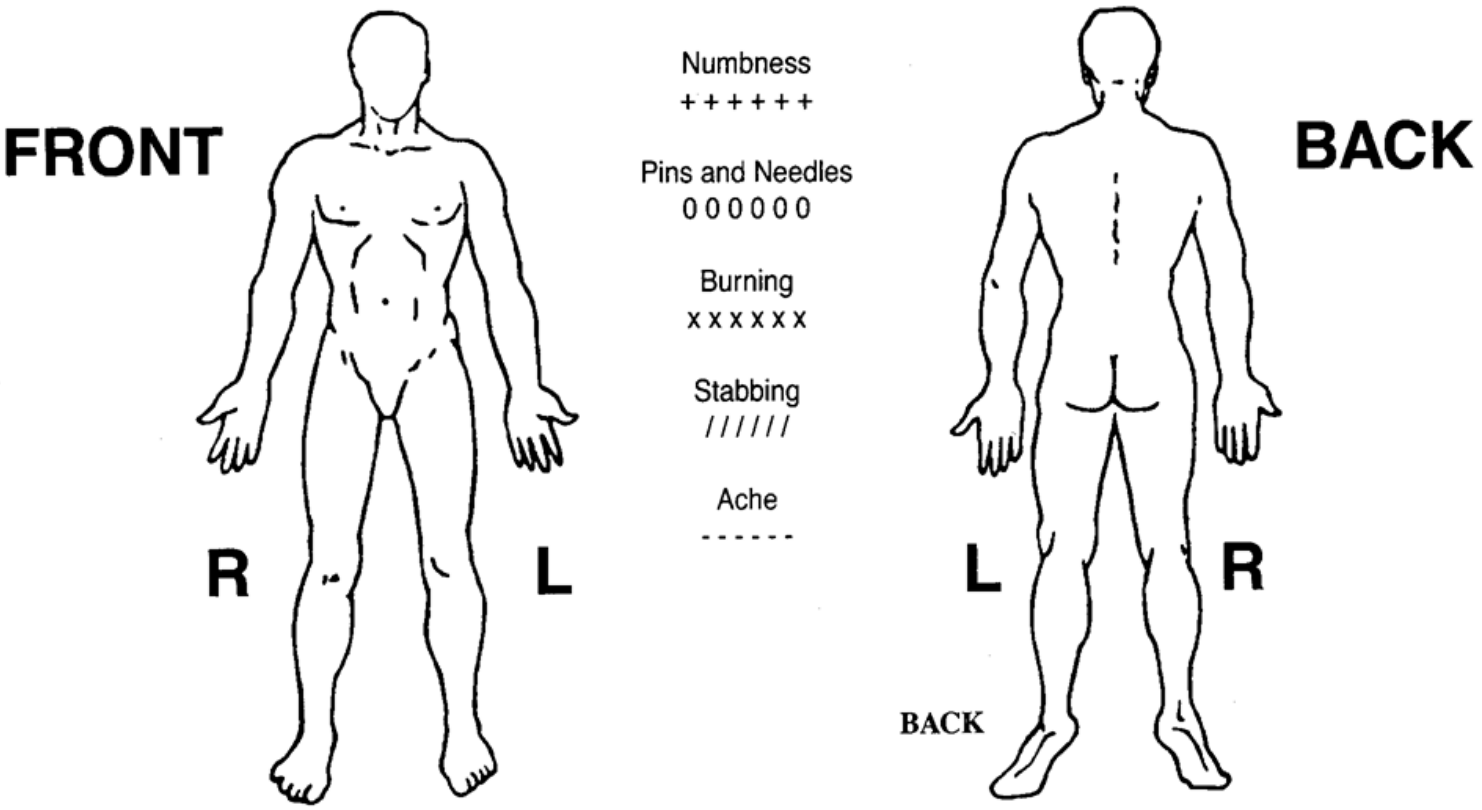
Height_____ft _____in Weight _____

Follow-up Information Sheet

NAME_____ **DATE**_____

PAIN DIAGRAM

Draw in the location of your symptoms in the diagram below using the symbols listed to indicate the type of pain you are experiencing.



PAIN SCORE

Assuming **0 represents no pain** imaginable and **10 represents the worst pain** circle the appropriate number

Pain level today	0	1	2	3	4	5	6	7	8	9	10
Best day over the last week	0	1	2	3	4	5	6	7	8	9	10
Worst day over the last week	0	1	2	3	4	5	6	7	8	9	10

SINCE YOUR LAST VISIT

Has the pain been ?	☐ Stable	☐ Improving	☐ Worsening
Any new associated symptoms?	☐ Numbness	☐ Weakness	☐ Other_____
New medical problem?	☐ No	☐ Yes (explain_____)	
Found meds helpful?	☐ No	☐ Yes	☐ N/A (not taking meds for pain)
Found therapy helpful?	☐ No	☐ Yes	☐ N/A (not taking therapy)