FOLLOW-UP PATIENT QUESTIONNAIRE

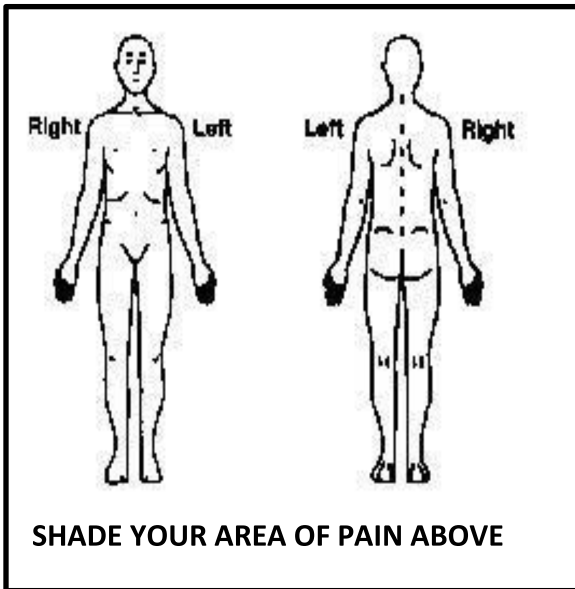
NAME:_______________________________ **DATE:** ___________

Are you following up with us after a procedure? Yes ____ No ____ % of relief obtained _______

What area of pain would you like to discuss today? ____________________________________

Do you have new imaging studies or tests to review? ____________________________________

Have you had recent physical therapy ? At home _____________ in office __________________



SHADE YOUR AREA OF PAIN ABOVE

Circle your average pain score over the past week:
0 1 2 3 4 5 6 7 8 9 10

Circle your highest and lowest pain score over the past week:
0 1 2 3 4 5 6 7 8 9 10

Do you require medication Refills? If so, please list below:

<u>Since your last visit, have you:</u>

Been prescribed new medication? ☐Yes ☐No
Been hospitalized or gone to the emergency room? ☐Yes ☐No
Developed new allergies? ☐Yes ☐No

If you answered yes to any of the above questions,
please document on the space provided to the right.

HEALTH MAINTENANCE QUESTIONS:

Do you smoke cigarettes or cigars? ☐Yes ☐No

If yes, would you like to enroll in a smoking cessation program? ☐Yes ☐No

Do you have a history of alcoholism? ☐Yes ☐No ☐Current Problem

Have you abused prescription drugs? ☐Yes ☐No ☐Current Problem

Have you abused illegal drugs? ☐Yes ☐No ☐Current Problem

Have you ever been in a drug or alcohol detoxification program? ☐Yes ☐No ☐Current Problem

FOLLOW-UP PATIENT QUESTIONNAIRE

NAME:_______________________________ **DATE:** ___________

QUALITY OF LIFE MEASURES

Are you able to exercise /perform physical therapy because of our care? ☐Yes ☐No

Please circle the best description of your MOOD:
Usually Happy *Sometimes Happy* *Sometimes Sad* *Usually Sad*

Does your pain affect your lifestyle? ☐Yes ☐No

Do you suffer from migraine headaches? ☐Yes ☐No

On average how many hours do you sleep at night? _________________

HEALTH STATUS: Height_______________ Weight _________________

REVIEW OF SYSTEMS: Please check all items you feel apply to you:
☐Recent gain of weight: ________pounds over one year____________
☐Recent loss of weight: ________pounds over one year____________

☐Fever	☐Shortness of Breath
☐ Joint stiffness	☐ HX OF Covid
☐Chest pain	☐Decreased Range motion
☐Loss Consciousness	☐Rash
☐Muscle weakness	☐Double or blurry vision
☐Constipation	☐Difficulty walking
☐Memory loss	☐Diarrhea
☐ Swelling (specify)	☐Nausea
☐Genital pain	☐Vomiting
☐Difficulty initiating urine stream	

Have you had your Covid Vaccine? ☐Yes ☐No

First (Date) _________________________ Second (Date) _____________________

Do you have a history of the following?

Hypertension ☐Yes ☐No

Depression ☐Yes ☐No

Pharmacy Information ____Phone____________________

Address____

Oct 2025