Name ______________________________________ Date _______________

Spine & Nerve Diagnostic Center Follow Up Pain Assessment

Please mark pain on the diagram to the right and rate the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (worst pain imaginable).

Pain level without medications :
0 1 2 3 4 5 6 7 8 9 10

Pain level with medications :
0 1 2 3 4 5 6 7 8 9 10

Have you had any new treatments or procedures since your last visit? If so, please list:

____
____

What medications are you taking for your pain currently?

____
____
____
____
____

Do you have any of the following symptoms? Please circle all that apply:

● Nausea ● vomiting ● insomnia ● headaches ● fever ● chills ● shortness of breath ● chest pain ● stomach upset ● sleepiness ● constipation ● diarrhea ● bladder problems ● depression

What is your work status? Please circle all that apply:

● working full duty ● working modified duty ● working part-time ● not working ● retired

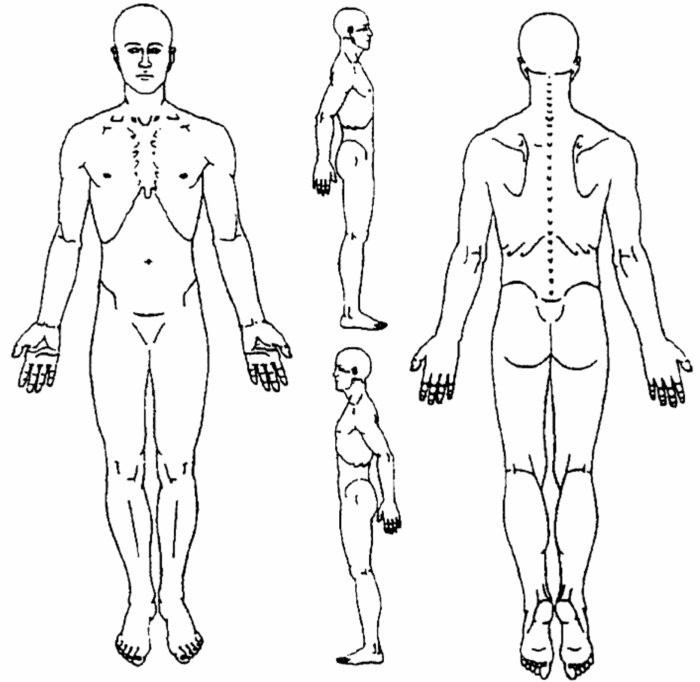
What is your job title?

____

Which activities make your condition worse?

● sitting ● standing ● walking
● bending ● lifting ● laying down

OFFICE USE ONLY:	
WEIGHT:	
B/P:	*HR:*



Aching ^^^^ Numbness 0000 Pins and Needles .... Burning xxxx Stabbing ///

Which of the following make your condition better?

● sitting ● standing ● laying down
● medications ● injections ● physical therapy

Circle those which apply to you:

● single ● married ● in a relationship
● smoker ● non-smoker ● drink alcohol rarely
● drink alcohol often ● do not drink alcohol

Compared to your previous visit, is your pain …

● better ● worse ● the same

Who is you primary care physician?

____

If you are represented by an attorney for your workers compensation or personal injury case, who is your attorney?

____