Center for Interventional
PAIN & SPINE

Revisit Form

BP: _____/_____ HR: _____

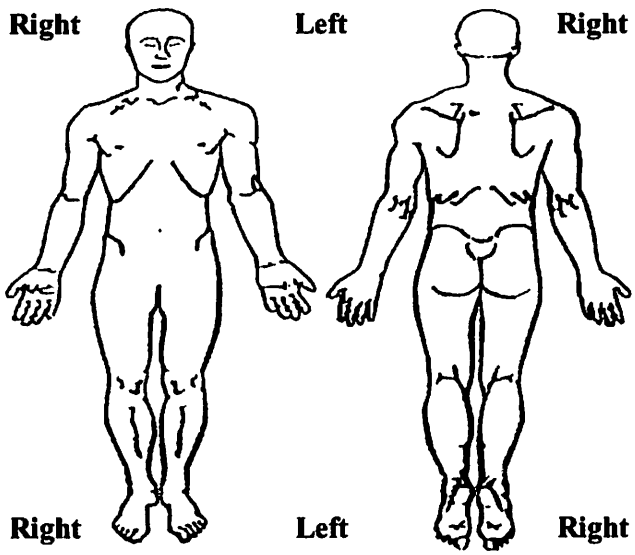
Wt: _____ Ht: _____

Name: _____ Today's Date: _____

Temp: _____

Date of Birth: _____

Pain Location(s): Please **shade** your area of pain:



Please check what qualities describe your pain:

☐ aching ☐ throbbing ☐ dull ☐ sharp ☐ burning
☐ shooting ☐ stabbing ☐ other: _____

Please check if you have associated symptoms:

☐ numbness ☐ tingling ☐ muscle spasm ☐ weakness
☐ bowel and bladder incontinence ☐ pins and needles ☐ None

Indicate the number between 0-10 that best describes your pain:

0 1 2 3 4 5 6 7 8 9 10

Does your pain interfere with activities of daily living:

Not at All Moderately Severely

Does your comprehensive conservative care help decrease your pain? (i.e. Medication Management, Home Exercises, Chiropractic Care, Physical Therapy)

NO YES

If you had a procedure at your last visit, did it provide 50% or more pain relief? _____ Specify pain relief %: _____

Please name medication(s) due for refill: _____

Please indicate the % of relief your medications provide and for how long: _____

Any side effects from medication(s): _____

Is there a chance that you may be pregnant? **Yes / No**

What worsens your pain? ☐ coughing ☐ straining ☐ standing ☐ walking ☐ sitting ☐ driving ☐ touch
☐ cold ☐ bending ☐ Other: _____

What makes your pain better? ☐ cold ☐ warmth ☐ sitting ☐ standing ☐ medication ☐ walking
☐ changing positions ☐ movement ☐ laying down ☐ rest
☐ Other: _____

Physician Notes Only