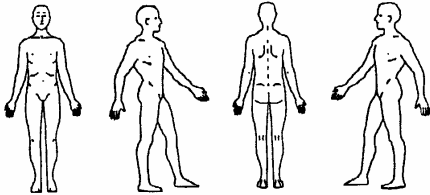


Follow up Pain Management Questionnaire

Name _____ Date _____

Please tell us in one sentence why you are here (e.g. "My back hurts.")

Please show us where you hurt:



How bad is the pain?

0	1	2	3	4	5	6	7	8	9	10
No Pain									Worst Pain Imaginable	

How is your mood:

0	1	2	3	4	5	6	7	8	9	10
Excellent									Terrible	

How well do you function:

0	1	2	3	4	5	6	7	8	9	10
Able to do everything									Unable to Function	

Which words describe the pain?

Throbbing Aching Sharp Dull Shooting Tingling
 Burning Numbness Hot Cold Continuous Intermittent

Have you had any new medications, operations or allergies? Yes ___ No ___

If yes, please explain: _____

Do you have any new medical problems? Yes ___ No ___

If yes please explain: _____

Please add any comments, which you feel, would be helpful in treating your condition.

Since your last appointment has there been any change to your address, phone number or insurance information:

Yes ___ No _____. If yes please explain: _____

I confirm that I am no harm to myself or others. (Please initial) _____

Your Signature: _____

<input type="checkbox"/> BBHI <input type="checkbox"/> UDS <input type="checkbox"/> INS. _____ Office use only
