MAGIC VALLEY
PAIN SPECIALISTS

FOLLOW-UP VISIT INTAKE PAPERWORK

Patient Name: ___________________________

Height: _____________ **Weight:** ____________

1. Where is your ONE worst area of pain?

____

2. What would you like to focus your visit on today?

____

3. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain imaginable

4. What number best describes, how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

5. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

6. Since your last visit, how is you pain?

☐ Better ☐ Worse ☐ Unchanged

7. Check all of the following that describe your pain:

☐ burning ☐ sharp ☐ shooting
☐ dull/aching ☐ constant ☐ cramping
☐ throbbing ☐ tingling ☐ spasm

8. What aggravates your symptoms?

☐ sitting ☐ sleeping
☐ walking ☐ up/down stairs
☐ squatting ☐ sitting to standing
☐ coughing ☐ standing to sitting
☐ standing ☐ household activities

9. What relieves your symptoms?

☐ heat ☐ sitting ☐ standing
☐ cold/ice ☐ rest ☐ stretching
☐ walking ☐ medication ☐ massage
☐ exercise ☐ lying down ☐ nothing
☐ other:

10. Are you currently taking any anticoagulants or blood thinners?

☐ Yes ☐ No

11. Since your last visit, have we performed an injection or procedure to try and help with your pain?

☐ Yes ☐ No

IF YOU RECEIVED AN INJECTION, please answer questions 12, 13, & 14.

12. What percentage of relief is the most relief you felt following the injection? (i.e., 10%, 50%, 90%)?

____

13. How long did you experience relief following the injection?

____

14. Is the pain as severe as it was before the injection?

____

PAIN MEDICATION FOLLOW UP:

15. What number best describes your pain with medications?

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain imaginable

16. What number best describes your pain without medications?

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain imaginable

Review of Systems

Please Check if you are experincing any of the following symptoms

Cardiovascular:	☐ lightheadedness	☐ swelling in the feet	☐ chest pain at rest	
Gastrointestinal:	☐ abdominal pain	☐ constipation	☐ nausea	
Musculoskeletal:	☐ neck pain	☐ back pain	☐ hip pain	☐ arm pain
	☐ muscle spasms	☐ muscle stiffness	☐ joint pain	☐ leg pain
Neurological:	☐ dizziness	☐ headaches	☐ numbness	☐ seizures
	☐ stroke	☐ tingling		