Name: ____Today's Date: ______________________________

LAST PRESCRIPTION FILL DATE: _____________________________________

Since the last visit, your overall pain has: ☐ Unchanged ☐ Improved ☐ Temporarily Improved ☐ Worse

Percentage of pain relief noticed compared to no treatment (injections/medications): ☐ 0% ☐ 25-50% ☐ 50-75% ☐ 75-100%

Percent of pain relief since the last **Injection/Procedure** (if applicable): ☐ 0% ☐ 25-50% ☐ 50-75% ☐ 75-100%

Location of pain: ☐ Low Back ☐ Neck ☐ Leg(s)-Right/Left ☐ Arm(s)-Right/Left ☐ Other___________________

Rate your pain by **circling** the one number that best describes your **AVERAGE** pain in the last 7 days.

0 1 2 3 4 5 6 7 8 9 10

No pain Worst imaginable pain

Which activity or position ***aggravates*** your pain?

☐ Sitting ☐ Standing ☐ Walking ☐ Other (please describe): _______________________________

Which activity or position ***relieves*** your pain?

☐ Sitting ☐ Standing ☐ Walking ☐ Other (please describe): _______________________________

REVIEW OF SYSTEMS: If you currently have a ***problem*** in any of these areas, please **check** below:

General
☐ Fevers
☐ Chills
☐ Weight loss

ENT
☐ Hearing loss
☐ Sore throat
☐ Difficulty Swallowing

Cardiovascular
☐ Chest pain
☐ Irregular heartbeat
☐ Blood clot

Respiratory
☐ Cough
☐ Shortness of Breath
☐ Wheezing

Gastrointestinal
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea

Urinary
☐ Kidney stones
☐ Difficult urinating
☐ Urinary incontinence

Neurological
☐ Sensation loss
☐ Fainting
☐ Seizures
☐ Headache
☐ Coordination loss

Skin
☐ Easy bruising
☐ Bleeding disorder
☐ Rash

Endocrine
☐ Heat/Cold Intolerance
☐ Excessive thirst
☐ Change in sexual desire

Psychiatry
☐ Depression
☐ Anxiety
☐ Panic attacks
☐ Suicidal ideation

Has there been **any** change in your medications since the **LAST** visit? ☐ Yes ☐ No
If yes, please list: ____

Any major changes in your health since your **LAST** visit? ☐ Yes ☐ No:
If yes, please list: ____

Has there been a recent surgery since you **LAST** visit: ☐ Yes ☐ No
If yes, please list: ____

Any new diagnostic test(s) since your last visit? ☐ Yes ☐ No
If yes, please list: ____

In what manner has your pain medication **improved** your quality of life?

☐ Mood ☐ Sleep ☐ Greater independence ☐ Increased physical activity ☐ No improvement

Are you overusing, misusing, selling your medications or having others use your medication? ☐ Yes ☐ No

Do you or others feel that your use of pain medications is causing problems with your mood or behavior? ☐ Yes ☐ No

Signature: ____Date: __________________________