BETTER LIFE
SPINE & PAIN CENTER

P: 832-286-4546
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12518 Cutten Road
Houston, Texas 77066

Pain Evaluation Form - Follow-up Patients

PATIENT NAME: _____ DATE OF BIRTH: _____

Since your last office visit, have your medications changed; have you been hospitalized; have you had surgery; has your family history changed? If yes, please specify: _____

Is medication helping improve your pain &/or functionality? If yes, what activities does it improve:
Sleeping Dressing Using bathroom Cooking Cleaning Shopping Hobbies Working

Do you have any side effects with your current pain medications (such as constipation or nausea)? _____

If you had a procedure since your last office visit, what percent of pain relief did you get? _____

Do you take any blood thinners? _____

Followup Patient Questionnaire

What number best describes your pain on average in the past week?
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (As bad as you can imagine)

What number best describes how, during the past week, pain has interfered with your enjoyment of life?
(None) 0 1 2 3 4 5 6 7 8 9 10 (Completely interferes)

What number best describes how, during the past week, pain has interfered with your general activity?
(None) 0 1 2 3 4 5 6 7 8 9 10 (Completely interferes)

Review of Systems (please select all that apply)

Constitutional: ❑Fever, ❑Night sweats, ❑Weight gain, ❑Weight Loss

EENT: ❑Dry mouth, ❑Frequent nosebleeds, ❑Snoring

Cardiovascular: ❑Chest pain, ❑Ankle swelling

Respiratory: ❑Cough, ❑Wheezing, ❑Shortness of breath

Gastrointestinal: ❑Nausea, ❑Vomiting, ❑Constipation, ❑Diarrhea, ❑Bloody vomit, ❑Heartburn, ❑Bloody stools, ❑Black or tarry stools,

Genitourinary: ❑Difficulty urinating, ❑Urinary incontinence

Musculoskeletal: ❑Muscle aches, ❑Joint pain, ❑Joint swelling, ❑Back pain, ❑Neck pain

Integumentary: ❑Rash

Neurological: ❑Weakness, ❑Numbness, ❑Seizures, ❑Dizziness, ❑Frequent/ severe headaches, ❑Dizziness, ❑Daytime sleepiness

Psychiatric: ❑Depressed mood, ❑Sleep disturbances, ❑Frequent anxiety, ❑Foggy thinking, ❑Suicidal thoughts

Endocrine: ❑Fatigue, ❑Excessive thirst, ❑Increased urination

Hematologic/ lymphatic: ❑Excessive bleeding from minor cuts, ❑Excessive bruising

Allergic/ immunologic: ❑Recent allergic reaction

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Only complete this section if your pain has **changed** or if you have **new areas of pain**.

Where is your pain (such as neck, low back, or knee)? _____

How long ago did your pain first begin? _____

Do you remember a specific accident or injury that started your pain? _____

Is your pain constant or intermittent? _____

Does anything make the pain better? _____

Does anything make the pain worse? _____

What words best describe your pain (circle all that apply):

Ache	Stiff	Sharp	Dull	Stabbing	Shooting
Tingling	Burning	Numb	Feels “asleep”	Electric	Other: _____

*Only complete this section if you have **neck** pain:* Does the neck pain go down your arms? _____ If yes, how would you describe this pain (circle all that apply): Tingling Burning Numb Feels “asleep” Electric Shooting Other:_____ Have you ever had neck surgery? _____	*Only complete this section if you have **low back** pain:* Does the back pain go down your legs? _____ If yes, how would you describe this pain (circle all that apply): Tingling Burning Numb Feels “asleep” Electric Shooting Other:_____ Have you ever had back surgery? _____