

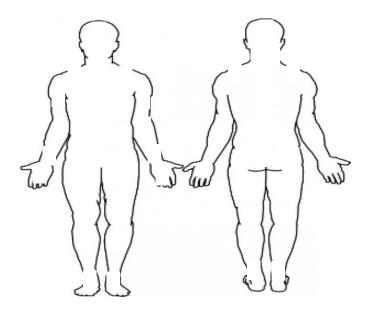
## Pain Management Follow Up

Patient Name:	DOB:	
Reason for visit:		
Location of pain:		
Check all that apply		
Radiating: Yes No If yes, where does the pain radia	ate to?	
Quality: dull aching sharp stabbing cramping shooting		throbbing
cramping shooting	Durring	
Pain Severity: current pain level/10 wo		
Alleviating factors: massage heat therapy cold the psychotherapy opioids/		distraction
Aggravating factors: movement stress		
ADL Improvements: physically functioning able to rundisturbed overall function im	·	
unable to maintain relationships mood affected sleep	patterns disturbed overall fun	ction not improved
Injection/procedure since last visit? Yes No Date: _	If so percent of r	elief:
Have you had any new surgeries or imaging since your last If Yes, please explain:		
Have you had an ER or Hospital visit since your last appoint If Yes, please explain:		
Who is your Primary Care Physician?		
Medications		
Preferred Pharmacy: Advanced Rx Other:	and Handling included).**	



## Pain Management Follow Up

## Please check where it hurts



Dationt Cinnature: Describe Initials: Describe Initials:	
Patient Signature: Employee Initials: Provider Initials:	