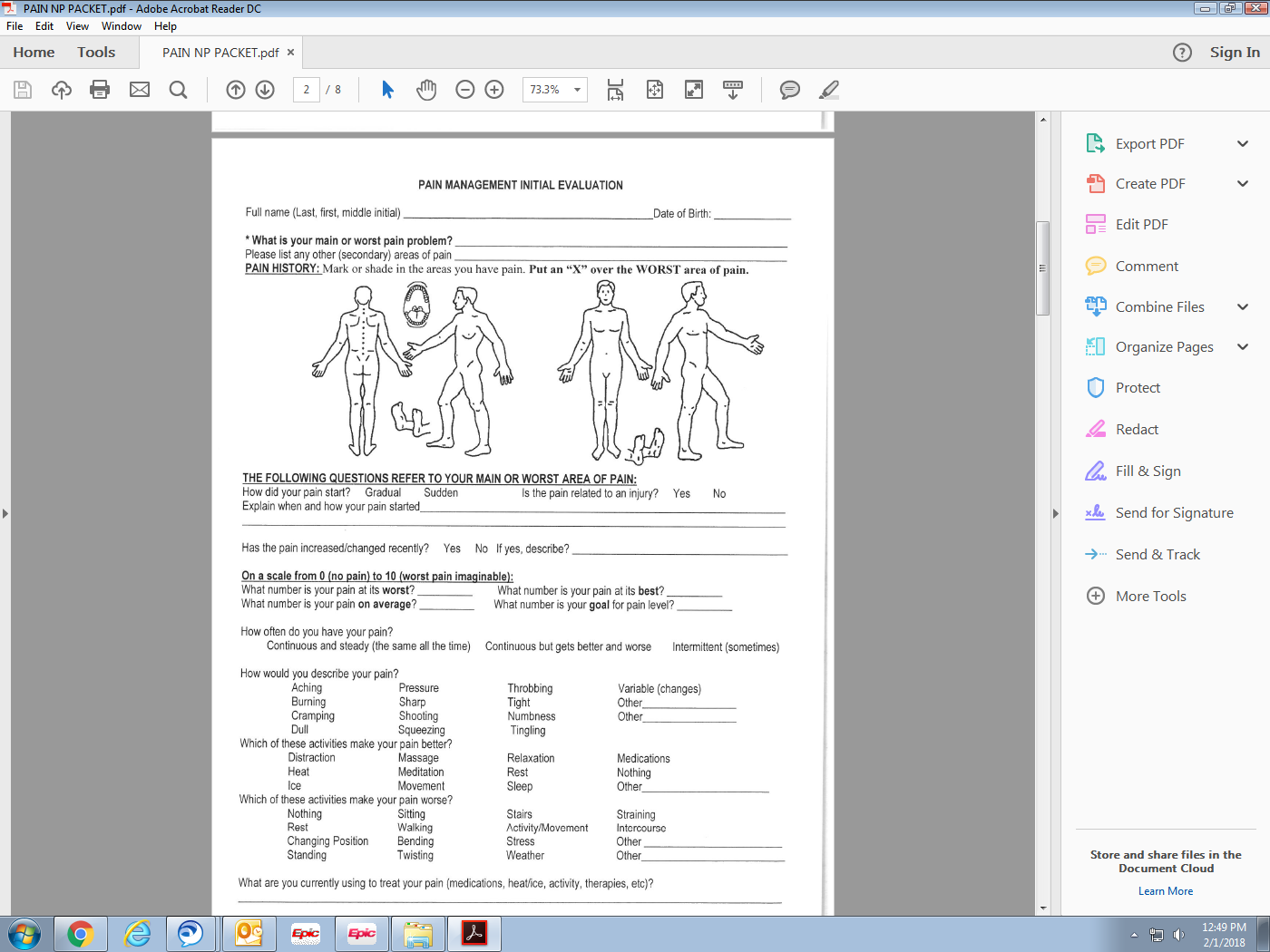
Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_  
 **Pain Management Return Visit Questionnaire**

Do You Need Prescriptions Today: YES NO

List of Questions or Concerns for Today’s Visit:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  
**Pain History:** Mark or Shade in the Areas You Have Pain (Put an X over the WORST area of pain)

**On a Scale from 0 (No Pain) to 10 (Worst Pain Imaginable)**What Number is Your Pain **RIGHT NOW**: \_\_\_\_\_\_\_   
What Number is Your Pain **ON AVERAGE** During the Last Week: \_\_\_\_\_

Has Your Pain Changed Recently:   
 NO YES If Yes, Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
In the Past Week, What Percentage of Relief Have Your Current Pain Treatments or Medications Provided:  
 0% being **NO RELIEF** and 100% Being **COMPLETE RELIEF**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Since Your Last Pain Clinic Visit, Has Your Activity Level and Ability to Perform Physical Tasks:  
 Increased / Unchanged / Decreased

Have there been any changes in your health since your last Pain Clinic visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been started on any new medication since your last Pain Clinic Visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you stopped taking any medication since your last Pain Clinic visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Review of Symptoms** (In the Last Month Have You Had: Check All That Apply)

|  |  |  |  |
| --- | --- | --- | --- |
| **Constitution** | **Eyes** | **Gastroenterology** | **Endocrinology** |
| * Fever | * Blurred Vision | * Heartburn | * Easy Bruising / Bleeding |
| * Chills | * Light Sensitivity | * Nausea | * Environmental Allergies |
| * Weight Loss | * Eye Pain | * Vomiting | * Excessive Thirst |
| * Fatigue | * Eye Discharge | * Abdominal Pain |  |
| * Excessive Sweating | * Eye Redness | * Diarrhea | **Neurological** |
| * Weakness |  | * Constipation | * Dizziness |
|  | **Cardiovascular** | * Blood in Stool | * Headaches |
| **Skin** | * Chest Pain | * Dark Stool | * Tingling |
| * Rash | * Palpitations |  | * Tremor |
| * Itching | * Shortness of Breath When   Laying Down | **Genitourinary**   * Painful / Difficult Urination | * Sensory Change * Speech Change |
| **Head/Ear/Nose/Throat**   * Hearing Loss | * Pain or Cramping   in Legs With Elevation | * Urgency * Frequency | * Weakness in One   Extremity or Muscle Group |
| * Ringing in Ears * Ear Pain | * Shortness of Breath &   Coughing at Night | * Blood in Urine * Flank Pain | * Seizures * Loss of Consciousness |
| * Ear Discharge |  |  |  |
| * Nosebleeds | **Respiratory** | **Musculoskeletal** | **Psychiatric** |
| * Congestion | * Cough | * Muscle pain | * Depression |
| * Sinus Pain | * Coughing Up Blood | * Neck Pain | * Suicidal Ideas |
| * Vibrating Nose   When Breathing | * Coughing Up Mucus * Shortness of Breath | * Back Pain * Joint Pain | * Substance Abuse * Hallucinations |
| * Sore Throat | * Wheezing | * Falls | * Nervous / Anxious |
|  |  |  | * Insomnia |
|  |  |  | * Memory Loss |