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
 |