1498 Jesse Jewell Pkwy, Suite A
Gainesville, GA 30501
678-257-2547 • Fax: 678-965-1798
www.thrivemedicalpartners.com

THRIVE
MEDICAL PARTNERS

Follow-up Pain Assessment Questionnaire

DATE: _____

NAME: _____
Last First Middle

Male Female (circle) AGE: _____ DOB: _____

Where is your pain?_____

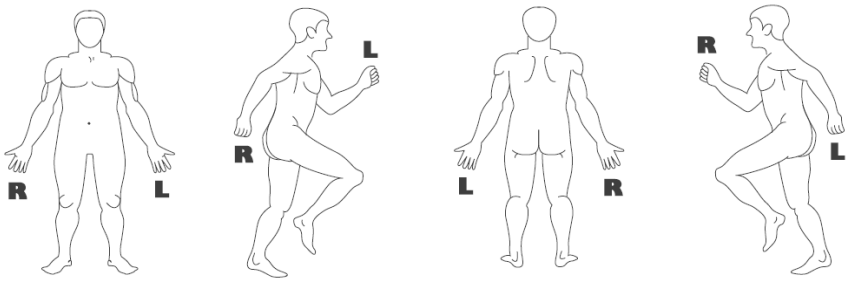
_____

Please check the words that best describe your pain.

☐Aching ☐Dull ☐Constant ☐Numbing ☐Coldness ☐Burning

☐Sharp ☐Stinging ☐Stabbing ☐Tingling ☐Cramping ☐Radiating

Please shade the area(s) of your pain.



Since your **LAST office visit,** have you had any pain management injections (interventional procedures)? ☐ Yes ☐ No

If yes, injection type, and date: _____

_____

Did you have any pain relief from the injection(s)? ☐Yes ☐No

If yes, how much pain relief did you receive?

☐10% ☐20% ☐30% ☐40% ☐50% ☐60% ☐70% ☐80% ☐90% ☐100%

Since your **LAST office visit,** have there been any changes in your pain medication regimen, or any new pain medications prescribed, either by your PVPS physician or by any other doctor(s)? ☐ Yes ☐ No

If yes, please list medication, dose, directions, and physician prescribing:_____

_____

Since your **LAST office visit,** have there been any changes in your medical condition, any new symptoms or diagnoses, or any changes in your family or living conditions? ☐ Yes ☐No

If yes, please explain: _____

_____

Patient Name: DOB:

Pain Scales

(0 = No pain 10 = Worst pain)

Please rate your present pain level.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please rate your worst pain level.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Please rate your average pain level.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Sleep Behavior Update

Your ability to sleep since your last office visit is: ☐ Improved ☐ Worsened ☐ Remained the same

Employment Status Update

How has your employment status changed since your last visit? _____

_____

Treatment Update

Since your **LAST office visit,** have you been hospitalized or had surgery for any reason? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Have you been seen by any other physician? ☐ Yes ☐ No

If yes, who and for what reason: _____

_____

_____

Current pain treatments include:

Treatment	No Relief	Moderate Relief	Excellent Relief	Date
Chiropractic Care	☐	☐	☐	_____
Home Exercise Program	☐	☐	☐	_____
Physical Therapy	☐	☐	☐	_____
TENS Unit	☐	☐	☐	_____
Traction	☐	☐	☐	_____
Orthotics/Bracing	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____

Do your pain medications provide pain relief? ☐ Yes ☐ No ☐ I do not take pain medications

If yes, how much pain relief do you receive?

☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Do your pain medications improve your function? ☐ Yes ☐ No ☐ I do not take pain medications
If yes, how much improvement in function do you receive?

☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Please indicate any side effects caused by your pain medications.

☐ Nausea ☐ Vomiting ☐ Rash ☐ Constipation ☐ Upset Stomach ☐ Sedation

☐ Dizziness ☐ Acid Reflux ☐ Itching ☐ No side effects ☐ Other: _____

Current Medications

☐ Please check off this box if you have reviewed the last dictation and your medications are unchanged. If your medications have changed, please list all medications that are currently prescribed to you:

Name	Strength	Directions	Prescribing Doctor

Review of Systems

Are you currently experiencing any of the following?

General		Neuro		Eyes		Respiratory	
Yes	No	Yes	No	Yes	No	Yes	No
☐	☐ Chills	☐	☐ Headaches	☐	☐ Visual changes	☐	☐ Shortness of breath
☐	☐ Night sweats	☐	☐ Dizziness			☐	☐ Persistent cough
☐	☐ Fever	☐	☐ Weakness (specify)_____			☐	☐ Difficulty breathing

Cardiovascular		Gastrointestinal		Skin		Genitourinary	
Yes	No	Yes	No	Yes	No	Yes	No
☐	☐ Chest pains	☐	☐ Nausea	☐	☐ Sores	☐	☐ Urinary retention
☐	☐ Abnormal heart beat	☐	☐ Vomiting	☐	☐ Rashes	☐	☐ Urinary incontinence
		☐	☐ Diarrhea			☐	☐ Urinary discharge
		☐	☐ Bowel incontinence				
		☐	☐ Constipation				

By signing below, I agree that I have completed this entire form and I have provided the correct information above. I also understand that I may receive a copy for my records.

_____

Signature of Patient / Guardian / or Patient Representative Date