Barr Center
for Innovative Pain & Regenerative Therapies

BP ____/____
Pulse____
Temp____

FOLLOW-UP QUESTIONNAIRE

Patient Name: _____ **Age:**___ **Date:** _____ **PCP:** _____

What are you here to see the Physician or Physician Assistant for today? _____

_____

Do you have a new problem to address today? __Y __N If so, what is it? _____

Date of last visit: _____. Since your last visit, are you: Better Worse Same _____

On a scale of 0-100%, how much better are you now? (If no better put 0%) _____%

On a scale of 0-10 (10 is the worst), how severe is your pain now? 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? __Sharp __Dull __Stabbing __Throbbing __Aching __Burning

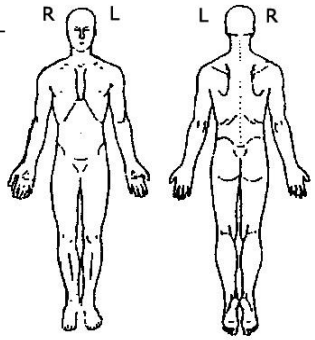
The pain is now: __Constant __Intermittent (Comes and goes) _____

Does your pain wake you from sleep? __Y __N _____

Do you have? __Numbness __Tingling __Weakness __Loss of bowel or bladder function __None

What makes your symptoms/pain worse? _____

What makes your symptoms/pain better? _____



How much does your pain interfere with your home life, relationships, work, hobbies and exercise? _____

What is the degree that your pain impacts your quality of life? _____

What is your pain stopping you from doing in your life? _____

Are there any changes in your family medical or social history? Y __N _____

How much stress is in your life? (0-None-10-Worst)_____What is the source of your stress? _____

How do you Manage your stress?_____

Exercise Program: _____

_____

What is your current job status? ___ Regular job __ Light Duty ___Not working due to this condition
___Do not work __ Retired ___ Change in job status:_____

	PRIOR TREATMENT	Did it help?	
	Anti-Inflammatories	_Yes	_No
	Narcotics	_Yes	_No
	Brace/Cast/TENS	_Yes	_No
	Physical Therapy	_Yes	_No
	Chiropractic/Acupuncture	_Yes	_No
	Home Exercise Program/Community Gym?	_Yes	_No
	Injection at last visit: Type:	_Yes	_No
	Surgery since last visit	_Yes	_No

Please list all current medication or provide a copy of medication list and supplements? _____

_____

_____

Since your last visit, have you,

Been prescribed new medications by any other physicians? __Y __N Describe: _____

Been hospitalized: __Y __N Describe: _____ Changed your prior smoking status? __Y __N _____

Since your last visit, have you developed any new problems in the following areas? (Please circle and describe)

Allergies: _____ *Nerves Lungs Eyes Skin Ears Stomach/Bowels Other Joints*

Diabetes Psychiatric Weight loss/fever Heart Urine Anemia Anxiety Depression

Describe any problems or concerns:_____

Please list any other questions you would like your doctor or PA to answer for you at this visit? _____

_____

Patient Signature: _____ MD/PA Signature _____ Date_____