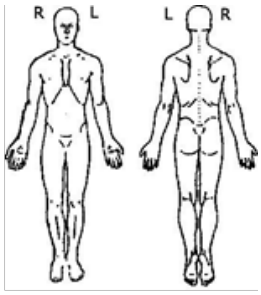
Barr Center
for Innovative Pain & Regenerative Therapies

HT:_____ WT:_____
BP:____/____

FOLLOW-UP QUESTIONNAIRE

Patient Name:_____ DOB:_____ Date: _____ PCP: _____
What are you here to see the Provider 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 ang goes) _____
Does your pain wake you from your 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 our 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	SINCE YOUR LAST VISIT HAVE YOU	
Anti- Inflammatories	Yes No	Been prescribed new medications by any other physician?If yes describe"	Yes No
Narcotics	Yes No	Been hospitalized? If yes describe:	Yes No
Brace/ Cast/ TENS	Yes No	Changed your prior smoking status?	Yes No
Physical Therapy	Yes No	Had surgery? If yes Describe:	Yes No
Chiropractic/ Acupuncture	Yes No		
Home Exercise Program/ Community Gym	Yes No		
Injection at last visit? Type:	Yes No		

REVIEW OF SYSTEMS:

CONSTITUTIONAL ☐ Fever ☐Weight Loss ☐Weight Gain ☐Weakness ☐Fatigue ☐Difficulty Sleeping ☐Chills ☐Night Sweats
EYES ☐ Visual Problems ☐Glaucoma
HENT ☐ Headaches ☐ Sinus Problems ☐ Hearing Problems ☐ Sleep Apnea
CARDIOVASCULAR ☐ Heart Trouble ☐ Swelling of feet ☐ Hypertension ☐ Lower Extremity Swelling
RESPIRATORY ☐ Cough ☐ Shortness of Breath
GASTROINTESTINAL ☐ Liver Disease ☐Hepatitis ☐Gall Bladder Problems ☐Reflux ☐Bowel Problems ☐Constipation ☐Diarrhea
GENITOURINARY ☐ Kidney Stone ☐Kidney Disease ☐Bladder Problems ☐Blood in Urine ☐Reduced Libido (desire for sex)
INTEGUMENT ☐ Dry Skin ☐Rashes
NEUROLOGICAL ☐ Seizures ☐Stroke ☐Peripheral neuropathy ☐Numbness ☐Memory or concentration difficulties
☐ Loss of Balance ☐ Falls ☐ Head Injuries
MUSCULOSKELETAL ☐ Neck Pain ☐Shoulder Pain ☐Elbow Pain ☐Wrist/Hand Pain ☐Carpal Tunnel Syndrome
☐ Low Back Pain ☐ Hip Pain ☐ Knee Pain ☐ Foot/Ankle Pain ☐ Gout
ENDOCRINE ☐ Thyroid Problem ☐ Diabetes ☐ Excessive Thirst
PSYCHIATRIC ☐ Depression ☐ Anxiety ☐ Anger ☐ Guilt
HEME-LYMPH ☐ Easy Bruising ☐ HIV Exposure ☐ Bleeding Problems
ALLERGIC-IMMUNOLOGIC ☐ Seasonal Allergy Allergies ☐ Anaphylactic (Severe) Medication Allergies ☐ Anaphylactic (severe) Reaction to Bee Stings

Describe any problems or concerns: _____
Patient Signature: _____ **MD/NP Signature:** _____**Date:** _____