Established Patient Visit Questionnaire

Patient Name: _____ Date: _____

Using the appropriate symbol, mark the area(s) on your body where you feel each of the following sensations.

Numbness	Pins and Needles	Burning	Aching	Stabbing
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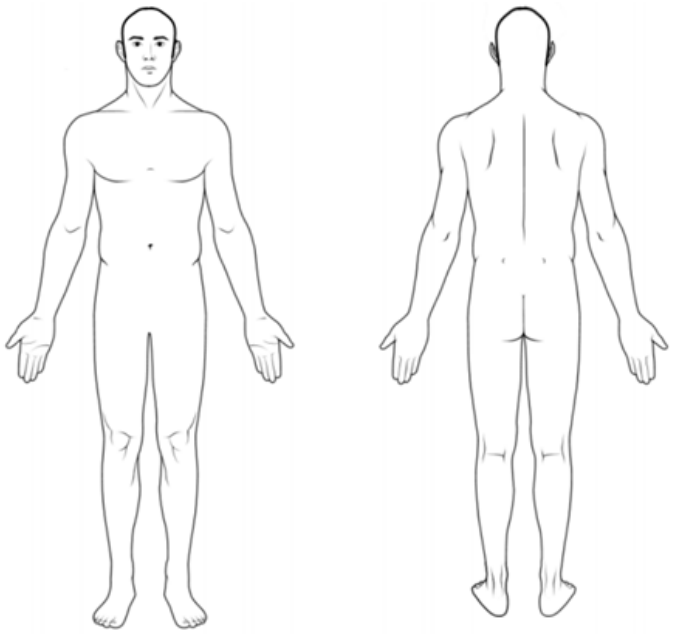

The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling at this time.

| _____ |

No Pain Worst Pain Ever

• _____ •

All Back/Neck Back/Neck Equals Arm/Leg All Arm/Leg

Location	Pain usually/now										
Back	0	1	2	3	4	5	6	7	8	9	10
Right Leg	0	1	2	3	4	5	6	7	8	9	10
Left Leg	0	1	2	3	4	5	6	7	8	9	10
Neck	0	1	2	3	4	5	6	7	8	9	10
Right Arm	0	1	2	3	4	5	6	7	8	9	10
Left Arm	0	1	2	3	4	5	6	7	8	9	10
Other_____	0	1	2	3	4	5	6	7	8	9	10

PRESENT MEDICAL INFORMATION

Which body part(s) is / are involved?
Neck: Arm: R L Shoulder: R L
Back: Leg: R L Knee: R L
Face/Head: Hip: R L Other:_____

Is there a new problem that was not evaluated at your last visit? No Yes, describe_____

How would you describe the pain? Dull / Aching Sharp/Stabbing Throbbing Tightness Burning
Other:_____

How often does the pain occur? Change in severity but always present Intermittent (comes and goes, sometimes no pain)

My pain symptoms are: Improving Getting worse Unchanged

Since your last visit, have you:

Been prescribed any new medications? No Yes, describe: _____
Received opioids/narcotics from another physician? No Yes, describe: _____
Been hospitalized or gone to the emergency room? No Yes, describe: _____
Developed any new allergies? No Yes, describe: _____

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ASSOCIATED SYMPTOMS

Do you have any of the following symptoms? And, if so, please describe:

	YES	NO	REMARKS
Numbness/tingling	☐	☐	Where: _____
Weakness in the arm or leg	☐	☐	Describe: _____
Bladder incontinence	☐	☐	If yes, is this a change from previously? ☐ Yes ☐ No
Bowel incontinence	☐	☐	If yes, is this a change from previously? ☐ Yes ☐ No
Numbness in the buttocks	☐	☐	_____
Morning stiffness in joints	☐	☐	How many hours? _____ Which joints?
Fever / chills	☐	☐	_____
Sleep Interrupted by pain	☐	☐	_____
Joint swelling	☐	☐	Whichjoints?_____
Headaches	☐	☐	_____
Vision problems	☐	☐	Explain:_____

Activities or hobbies limited due to pain:_____

Do you exercise on a regular basis? ☐ Yes ☐ No How often?_____ times per week

Type of exercise: _____

Non-medication modality that I tried _____

The non-medication modality that helped me the most _____

Physical therapy Details

- Have you had physical therapy for this problem? ☐ Yes ☐ No If Yes When/ Where
- Did this therapy help? ☐ Yes ☐ No explain
- Do you do any special exercises for your back or neck? ☐ Yes ☐ No explain

Did you experience any side effects from the medications prescribed last time? ☐ No ☐ Yes, describe: _____

_____

Has there been any change in your history since your last visit i.e., new surgeries, medical diagnoses, pregnancy status, blood thinner medication, aspirin products, pacemaker/defibrillator etc. Yes ☐ No ☐ If yes, explain. If no initial: _____

_____

Investigation history

List any tests you have had such as MRIs, X-rays, CT scans or have you seen any Physicians that we would need to get copies of office visit note.

☐ Yes ☐ No If yes, please explain _____

If following up from an injection

Injections were given for pain of which body part ☐ Neck. ☐ Back ☐ Arm ☐ Leg ☐ Joints ☐ SI-joints

Side _____ Other_____

How much pain relief did you obtain for the above region after the injection during initial period of first day %_____ at this visit _____

How much period of Significant pain relief did you obtain after the injection_____ weeks

How much functional improvement did you achieve %_____

There was reduction in pain Medications by what %_____

Review of Systems for Today

Constitutional:	☐ Chills	☐ Difficulty Sleeping	☐ Easy Bruising	☐ Night Sweats
	☐ Fatigue	☐ Fevers	☐ Insomnia	☐ Low sex Drive
	☐ Tremors	☐ Unexplained Weight Gain	☐ Weakness	☐ Unexplained Weight Loss
Eyes:	☐ Recent Visual changes			
Ears/Nose/Throat/Neck:	☐ Dental Problems	☐ Earaches	☐ Hearing Problems	☐ Nosebleeds
	☐ Sinus problems			
Cardiovascular:	☐ Chest Pain	☐ Bleeding Disorder	☐ Blood Clots	☐ Fainting
	☐ Palpitations	☐ Swelling in feet	☐ Shortness of breath during sleep	

Established Patient Visit Questionnaire

Respiratory:	Cough	Wheezing	Shortness of breath	
Gastrointestinal:	Constipation	Acid Reflux	Abdominal Cramps	Diarrhea
	Nausea/Vomiting	Hernia		
Musculoskeletal:	Back Pain	Joint Pains	Joint Stiffness	Joint Swelling
	Muscle Spasms	Neck Pain		
Genitourinary/Nephrology:	Flank Pain	Blood in Urine	Painful Urination	
	Decreased Urine Flow/Frequency/Volume			
Neurological:	Dizziness	Headaches	Tremors	Numbness/Tingling
	Seizures			
Psychiatric:	Depressed Mood	Feeling Anxious	Stress Problems	Suicidal Thoughts
	Suicidal Planning	Thoughts of Harming Others		

All other review of systems negative

Please fill up the Functional scores if you are following up after the Surgery or more than 6 weeks from the last visit to know your functional status.

Please fill-up ODI for low back and NDI for the Neck in the following Sheet

SECTION 1 - Pain Intensity
- I can tolerate the pain I have without having to use pain medication.
- The pain is bad, but I can manage without having to take pain medication.
- Pain medication provides me with complete relief from pain.
- Pain medication provides me with moderate relief from pain.
- Pain medicatoin provides me with little relief from pain.
- Pain medicatiopn has no effect on my pain.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed, I was with difficulty, and I stay in bed.

SECTION 3 - Lifting
- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveninently positioned, for example, on a table.
- Pain prevents me from lifting heavy weights,but I can manage light to medium weights if they are conveniently positioned.
- I can lift very light weights.
- I cannot lift or carry anything at all.

SECTION 4 - Walking
- Pain does not prevent me walking any distance.
- Pain prevents me from walking more than 1 mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me sitting more than one hour.
- Pain prevents me sitting more than 30 minutes.
- Pain prevents me sitting more than 10 minutes.
- Pain prevents me sitting at all.

SECTION 6 - Standing
- I can stand as long as I want without extra pain.
- I can stand as long as I want, but it increase my pain.
- Pain prevents me from standing for more than I hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTION 7 - Sleeping
- Pain does not prevent me from sleeping well.
- I can sleep well only by using pain medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

SECTION 8 - Social Life
- My social life is normal and does not increase my pain.
- My social life is normal, but it increase my level of pain.
- Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

SECTION 9 - Social Life
- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts my travel over 1 hours.
- My pain restricts my travel to short necessary journeys under ½ hour.
- My pain prevents all travel except for visits to the physician therapist or hospital.

SECTION 10 - Employment / Homemaking
- My Normal homemaking / job activities do not cause pain.
- My Normal homemaking / job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking / job duties, but pain prevents me from performing more physically stressful activites (e.g., lifting, vacuuming).
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.