Today's Date: _____ **SPINE & PAIN CARE FOLLOW-UP QUESTIONNAIRE** **Staff CHECK :** DHEC □ RUDS □

PLEASE PRINT AND ANSWER ALL QUESTIONS. We may delay your appointment if no answer is provided or answer is not legible. Don't write "same" or " unchanged", we need to VERIFY your insurance at every visit. SAVE TIME: Download this form from 373pain.com and fill-out prior to next appointment.
Did you remember to bring your medication bottles? If not, you may be turned away from your appointment.

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Email Address: _____ Best Phone # to contact you: _____
(For online health record access and appointment reminders)
Insurance: _____ **Policy Number:** _____

Family Doctor: _____Psychiatrist: _____PHARMACY: _____Zip_____ tel #_____
Check here if above information has changed since last visit: NO □ YES □
I confirm that the information provided here are true and accurate. sign here:_____

1. **Do you have any new areas of pain?** NO □ I still hurt most in my _____ _____
   YES □ , I have new pain (list areas, describe in detail on the BACK SIDE of this page):_ _ _ _ _ _ _ _
2. **Circle the number indicating your pain today:** (none) 1 2 3 4 5 6 7 8 9 10 (severe)
3. **What best describes your pain today and since your last visit** *(circle all that apply):*
   - Dull Sharp Aching Stabbing Throbbing Weakness Giving out Shooting Burning
   - When has this pain been worse? *(circle all that apply):* In the: Morning Daytime Evening Night
   - When you: Lift things Bend Lie down Sit Stand Drive Walk Change positions
4. **When you were last here**, what advice did you receive? ☐medication/prescriptions ☐ injection or procedure
   Are you returning after x-ray, CT or MRI scan? NO □ YES □ other :_ _ _ _ _ _ _ _
5. **I am better by :** 0% 10 20 30 40 **50** 60 70 80 90 100% **after my last visit.**
   - What do you think would make your treatment more effective? (if nothing, answer N/A) :_ _ _ _ _ _ _ _
6. **Since your last visit** : Did you get any **Pain Killers** from others or has any existing prescription of yours changed? NO □ YES □ *(please list AND describe any changes, use the back of this page for more space):* _ _ _ _ _ _ _ _
   - Did you discover any new allergies? NO □ YES □ *(please describe):*__
   - Have you borrowed or shared any pain meds? NO □ YES □ *(please describe):*__
   - Did you run out of pain medication? NO □ YES □ *(please describe):*__
   - Are you taking any illegal or street drugs? NO □ YES □ *specify:* _____Have you experienced any significant health events or changes? NO □ YES □ **Describe in detail on the BACK SIDE of this page->**

For DOCTOR use only – do not write BELOW this area

EDIT O: General:
Msk:

EDIT A:

EDIT P: **ORDERS:** MEDS / INJ / PT / DME / WORK / IMAGING / EMG/ Counseling / eRX/ PHR / RUDS / other: FU Wk GVL. ESL. AND. prn

□ No confirmation
□Ordered confirmation:

UDS /Point of care random urine report: MET -- AMT -- THC -- COC -- OPI/MOP -- BAR -- BZO -- PCP --MTD --OXY -- MDMA -- BUP –
Report OKAY to release Opioids today. Do not release Opioids. □ Taper opioids □

Dr. Thiyaga
reviewed & signed

REVISED 9/01/2013 *VITALS BP:* *PULSE:* *WT:* *OTHER:*