PATIENT FIRST NAME: ____________________ LAST NAME: _________________________

DATE OF VISIT: __________________________ PROVIDER: Shea OR Dr. Rosenblum

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1. WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY?

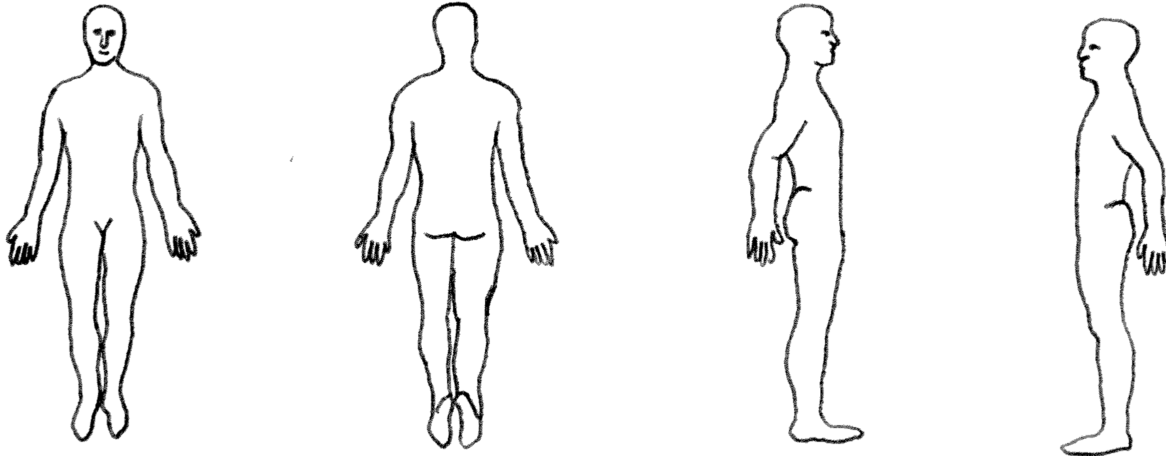
_____ Scheduled, Routine Follow-Up
_____ Urgent Medication Issue
_____ TPI/ Botox Injections
_____ New Problem, New Illness or New Injury

2. HOW WOULD YOU DESCRIBE YOUR SYMPTOMS SINCE YOUR LAST VISIT?

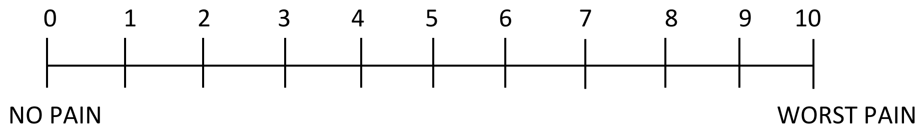
_____ Back Pain
_____ Bone Pain
_____ Headache
_____ Joint Pain
_____ Joint Stiffness
_____ Limb Pain
_____ Muscle Spasms
_____ Nausea/Vomiting
_____ Neck Pain
_____ Numbness
_____ Weakness
_____ Weight Loss

Other: __________________________
____
____
____
____
____

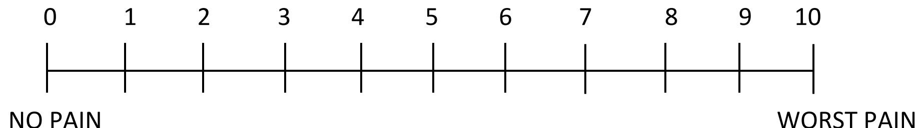
3. CURRENT LOCATION OF PAIN: (SHADE IN THE PAINFUL AREAS ON THE DIAGRAM BELOW)



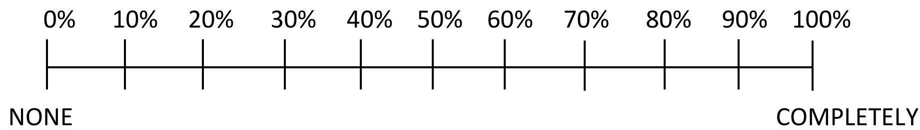
4. ON A SCALE OF 0-10, WHAT IS YOUR CURRENT PAIN LEVEL?



5. WHAT HAS BEEN YOUR AVERAGE PAIN LEVEL OVER THE LAST MONTH?



6. HOW MUCH IS YOUR CURRENT PAIN MANAGEMENT THERAPY REDUCING YOUR PAIN?



7. DOES YOUR CURRENT PAIN MANAGEMENT TREATMENT IMPROVE YOUR FUNCTION FOR THESE SPECIFIC THINGS?

	Yes	No
General Activity		
Mood		
Walking		
Normal Work (Includes work outside the home & housework)		
Relationships with other people		
Enjoyment of life		
Sexual Activity		
Sleep		

8. ARE THERE ANY MAJOR **NEW** PROBLEMS OR SIDE EFFECTS WITH YOUR CURRENT TREATMENT?

____ Nausea ____ Itching ____ Confusion Other: ___________________________
____ Vomiting ____ Dizziness ____ Sweating ________________________________
____ Constipation ____ Sleepiness ____ Anxiety ________________________________
____ Dry Mouth ____ Shortness of Breath

9. HOW WOULD YOU DESCRIBE THE QUALITY OF YOUR SLEEP EACH NIGHT?

_____ POOR _____ FAIR _____ GOOD _____ EXCELLENT

10. DO YOU EXPERIENCE FEVERS, NIGHT SWEATS, INTOLERANCE TO HEAT/COLD, UNANTICIPATED WEIGHT CHANGES?

____ NO OR ____ YES IF YES, PLEASE EXPLAIN: ____

11. DO YOU HAVE ANY NEW MUSCLE OR BONE DISORDERS, NEW PROBLEMS WITH JOINT/ARTHRITIS, NEW TROUBLE WITH ARMS AND/OR LEGS?

____ NO OR ____ YES IF YES, PLEASE EXPLAIN: ____

12. DO YOU HAVE A HISTORY OF STROKE, SEIZURE, NEUROPATHY, NERVE INJURY OR OTHER NEW NEUROLOGIC SYMPTOMS.

____ NO OR ____ YES IF YES, PLEASE EXPLAIN: ____

13. DO YOU HAVE ABDOMINAL PAIN, STOMACH ULCERS, HIATAL HERNIA, BOWEL PROBLEMS, BLEEDING, GALLBLADDER PROBLEMS, HEPATITIS, OR LIVER PROBLEMS?

____ NO OR ____ YES IF YES, PLEASE EXPLAIN: ____

14. DO YOU HAVE A COUGH, ASTHMA, COPD, CHRONIC BRONCHITIS, OR SHORTNESS OF BREATH?
____ NO OR ____ YES IF YES, PLEASE EXPLAIN: ____

15. DO YOU EXPERIENCE CHEST PAIN, HAVE A HISTORY OF HEART ATTACK, BLOOD FLOW PROBLEMS, IRREGULAR RYTHYM, AND/OR HIGH BLOOD PRESSURE?
____ NO OR ____ YES IF YES, PLEASE EXPLAIN: ____

16. LIST ANY MEDICATIONS THAT HAVE CHANGED SINCE YOUR LAST APPOINTMENT:

Name of Medication	Dose (mg)	How many?	How often?	What is this medication for?

17. LIST ANY NEW ALLERGIES (NOT PREVIOUSLY LISTED):

Name of Medication	What reaction did you have to this medication?

18. PHARMACY NAME: ____________________________ LOCATION: ________________________________

Internal use only.

Plan:

- Follow up in ____________ months
- PT/Referral to ________________
- Medication Management Agreement
- Procedure ____________________
- Lab/Imaging___________________
- UDT