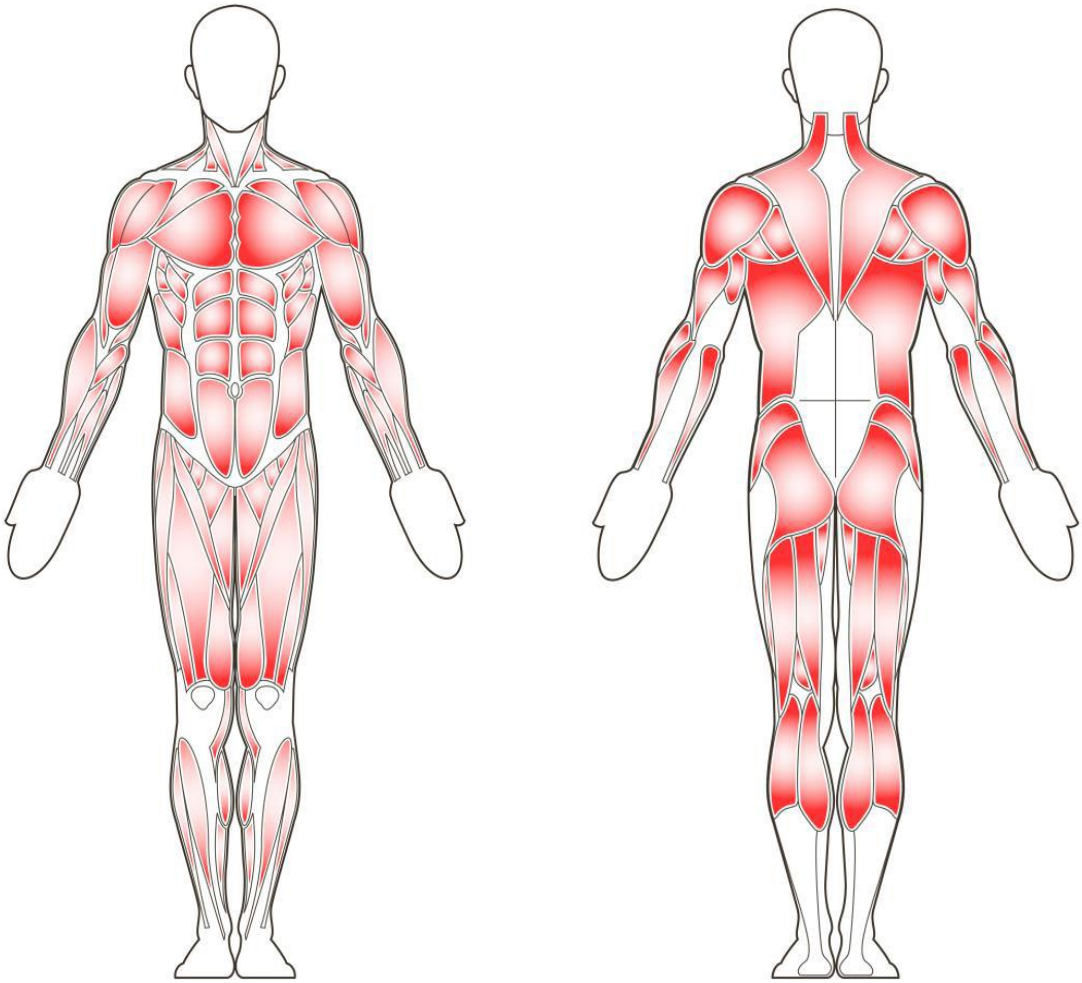
Pain Diagram

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
----------	oooooooooooooo	^^^^^^^	XXXXXX	ϕϕϕϕϕϕ



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

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Follow-Up Questionnaire – Spine/Pain

GE ID #:_____ **Date:**_____
CORE Provider: #:_____
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PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____
E-Mail: _____ Height: _____ Weight: _____
Reason for Visit: _____

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? ☐Changes 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: _____

PAIN LEVEL – Numerical Rating Scale (0 to 10)

Current pain level:	***No Pain*** ☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 -***Worst***
Lowest level in past week:	***No Pain*** ☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 -***Worst***
Worst level in past week:	***No Pain*** ☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 -***Worst***

ACTIONS AFFECTING PAIN LEVEL

*If you have **BACK** pain, please address the following activities (otherwise, skip this section):*

	WORSE	BETTER	NO EFFECT	REMARKS
Bending forward	☐	☐	☐	
Leaning back	☐	☐	☐	
Sitting	☐	☐	☐	
Standing	☐	☐	☐	
Walking	☐	☐	☐	
Activity	☐	☐	☐	
Rest	☐	☐	☐	
Lying flat	☐	☐	☐	
Lying with hips and knees bent	☐	☐	☐	
Rising out of bed/chair	☐	☐	☐	
Coughing/Sneezing	☐	☐	☐	

Other: _____
Which of these activities is the most bothersome? _____
What helps the most to improve your pain?

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ACTIONS AFFECTING PAIN LEVEL

*If you have **NECK** pain, please address the following activities (otherwise, skip this section):*

	WORSE	BETTER	NO EFFECT	REMARKS
Looking down towards ground	☐	☐	☐	
Looking up towards ceiling	☐	☐	☐	
Turning head towards left	☐	☐	☐	
Turning head towards right	☐	☐	☐	
Computer or watching TV	☐	☐	☐	
Driving	☐	☐	☐	
Coughing / Sneezing	☐	☐	☐	
Overhead activities (with arms)	☐	☐	☐	

Other: _____

Which of these activities is the most bothersome? _____

What helps the most to improve your pain? _____

*If you have **PAIN ANYWHERE ELSE**, please fill out this section (otherwise, skip this section):*

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

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	☐	☐	Which joints? _____
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:

SOCIAL HISTORY

Occupation: _____ When was the last time you worked? _____

☐Light-duty ☐Temporary disability ☐Permanent ☐Student ☐Retired ☐Unemployed/Seeking job

Are you currently under worker's compensation? ☐No ☐Yes Is there an ongoing lawsuit related to your visit today? ☐No ☐Yes

Tobacco: ☐No ☐Yes ☐Quit How many packs per day? _____ How many years? _____

Alcohol: ☐No ☐Yes ☐Quit How much do you drink daily?

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	Do you currently or have you ever abused alcohol	☐No	☐Yes
Illicit Drugs:	Are you currently using any illicit substances?	☐No	☐Yes
	Type: ☐Marijuana ☐Other:		

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

General			**Endocrine**		
Loss of Appetite	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Recent Weight Loss	☐Yes	☐No	Heat/Cold Intolerance	☐Yes	☐No
Respiratory			**Cardiovascular**		
Shortness of Breath	☐Yes	☐No	Chest Pain	☐Yes	☐No
Chronic Cough	☐Yes	☐No	Palpitations	☐Yes	☐No
Kidney/Bladder/Urine			**Eyes**		
Painful Urination	☐Yes	☐No	Blurred Vision	☐Yes	☐No
Blood in Urine	☐Yes	☐No	Double Vision	☐Yes	☐No
Kidney Problems	☐Yes	☐No	Loss of Vision	☐Yes	☐No
Gastrointestinal			**Skin**		
Nausea or Vomiting	☐Yes	☐No	Frequent Rashes	☐Yes	☐No
Blood in Stool	☐Yes	☐No	Skin Ulcers	☐Yes	☐No
Heartburn	☐Yes	☐No	Lump	☐Yes	☐No
Constipation	☐Yes	☐No	Psoriasis	☐Yes	☐No
Neurological			**Head/Ears/Nose/Throat**		
Headaches	☐Yes	☐No	Hoarseness	☐Yes	☐No
Seizures	☐Yes	☐No	Trouble Swallowing	☐Yes	☐No
Dizziness	☐Yes	☐No	Hearing Loss	☐Yes	☐No
Hematologic/Lymphatic			**Psychiatric**		
Easy Bruising	☐Yes	☐No	Depression	☐Yes	☐No
Easy Bleeding	☐Yes	☐No	Drug/Alcohol Addiction	☐Yes	☐No
			Suicidal Thoughts	☐Yes	☐No

Are there any questions you would like the doctor to address for you at this visit?

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient / Representative Name: _____

Patient Signature: _____ Date: _____

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Reviewed By: _____ **Date:** _____