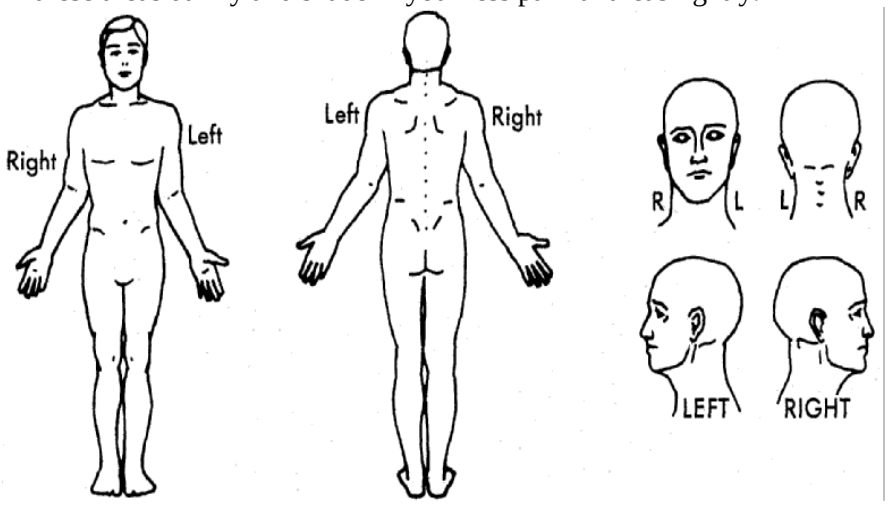
FOLLOW UP QUESTIONNAIRE

Name_____ **Date**_____

Have you had an MRI or x-ray since your last visit? **YES** **NO**
Have you had surgery since your last visit? **YES** **NO**

Where is your pain?

Please use the diagram below to indicate where your most painful areas are located. Shade in these areas darkly and shade in your less painful areas lightly.



Using the scale below, please rate the level of your pain on a scale of 0 (no pain) to 10 (worst pain imaginable) for the following:

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst pain imaginable)

PRESENT level of pain_____ **WORST** level of pain you've had in the past 24 hours_____

LEAST amount of pain you've had in the past 24 hours_____

AVERAGE level of pain_____

How would you describe your pain? (Circle.) aching throbbing sharp dull shooting burning

What factors INCREASE your level of pain?_____
_____

What factors DECREASE your level of pain?_____
_____

Are there any changes to your Current Medications?

_____

Are you experiencing any side effects from your medications? □ YES □ NO

If yes, what side effects ?_____

Are the side effects tolerable? □ YES □ NO

Using the scale below, list the number that best describes how pain currently affects your daily functioning.

Non-functional									Fully Functional		
0	1	2	3	4	5	6	7	8	9	10	general activity
0	1	2	3	4	5	6	7	8	9	10	mood
0	1	2	3	4	5	6	7	8	9	10	walking ability
0	1	2	3	4	5	6	7	8	9	10	normal work routine
0	1	2	3	4	5	6	7	8	9	10	sleep
0	1	2	3	4	5	6	7	8	9	10	appetite
0	1	2	3	4	5	6	7	8	9	10	relationships with others
0	1	2	3	4	5	6	7	8	9	10	enjoyment of life

(Office staff to complete) CRISP Checked _____
Date Opiod Agreement Signed _____
Last UDS _____

Signature_____ Date_____