

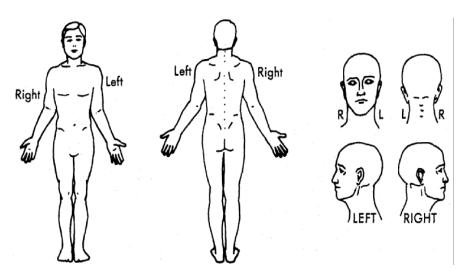
INSURANCE	
UDS	
CRISP	
RADIOLOGY	

FOLLOW UP QUESTIONNAIRE

Name	DOB:		Date	
Have you had an MRI or x-ray since your last v	isit?	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_____

What factors DECREASE your level of pain? ______

PLEASE COMPLETE PAGE 2



Are there any changes to your Current Medications?

When was the last dose of your pain medication taken?

DATE: _____ MEDICATION: _____

DATE: _____ MEDICATION: _____

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 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

Do you have an Advanced Directive?YESNODid you receive a flu shot this year?YESNO

For patients 65 & older

Are you considered a Fall Risk YES NO

If Yes: How many times have you fallen within the last 12 months? _____

Signature_____

Date: _____

ONCE COMPLETE, PLEASE RETURN TO FRONT DESK