Maryland Pain&Spine Center LLC

INSURANCE	
UDS	
CRISP	
RADIOLOGY	

FOLLOW UP QUESTIONNAIRE

Name________________________________ DOB:__________ 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.

Right Left Left Right R L L R LEFT RIGHT

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? aching throbbing sharp dull shooting burning numbness tingling

What factors INCREASE your 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? **YES** **NO**
Did you receive a flu shot this year? **YES** **NO**

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