Comprehensive Pain Management Group
Return Visit Questionnaire

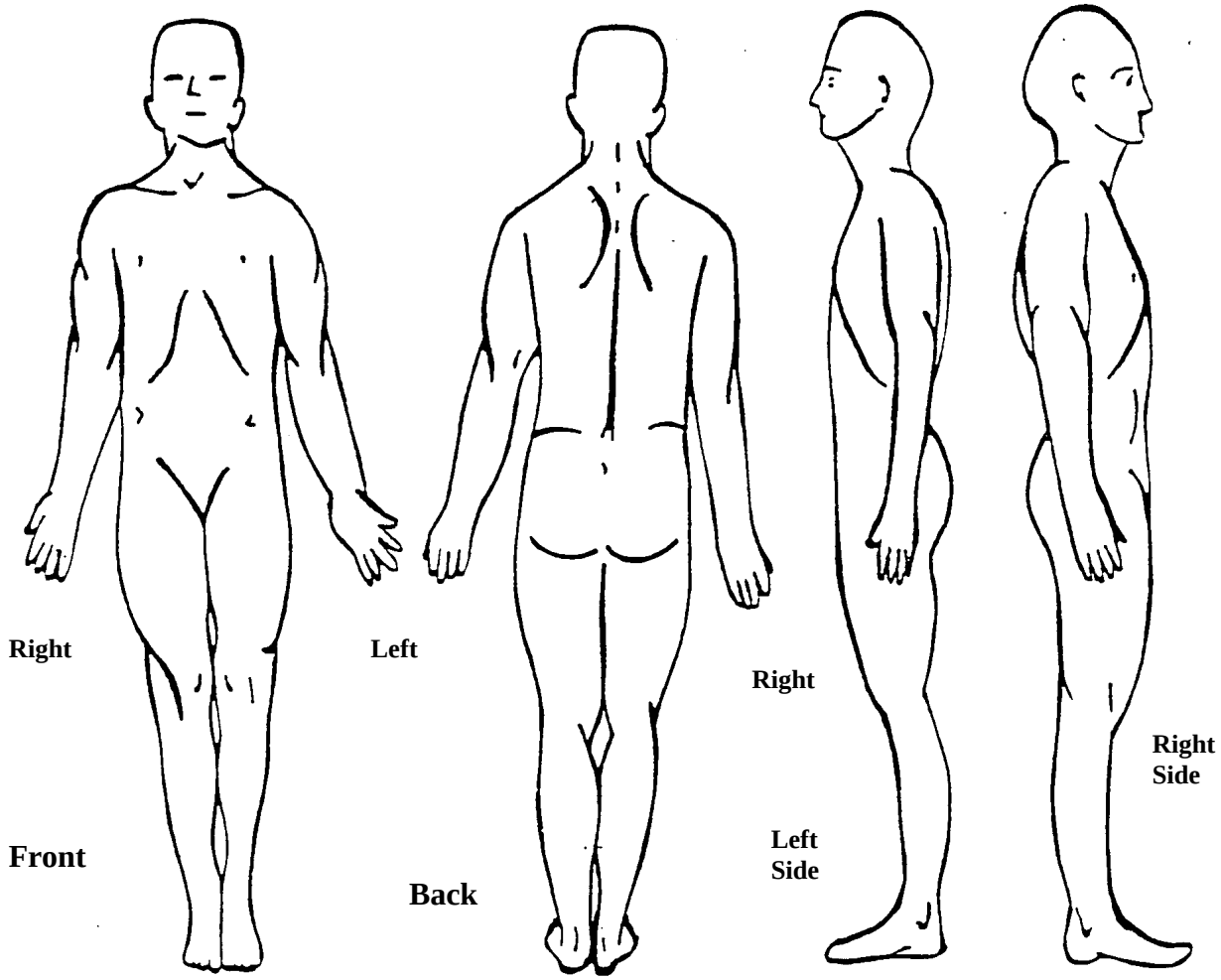
Name: _____

Visit Date: _____

Reviewed with patient by: _____ **Date:** _____

I. LOCATION:

A. Shade in the areas of your body that have pain in **red**, *and numbness in* **blue**.
B. Place "X1" next to area of greatest pain.
C. Place "X2" next to area of second greatest pain. For office use: BP: HR: O2 sat:



II. Intensity: VAS Pain Rating Scale

1. a. Rate your **current** feelings of pain on the scale.
(0 is **no pain** and 10 is the **worst** pain you can imagine.)

0 1 2 3 4 5 6 7 8 9 10
No pain ⟵ ⟶ Worst possible pain

b. Rate your pain when you are at rest and when you move. (0 - 10)

Rest pain score: _____ Movement pain score: _____

2 **Activities of Daily Living**

(Please check the box for Better, Same or Worse for each item below.)

		Better	Same	Worse
a.	Physical Functioning	☐	☐	☐
b.	Family Relationships	☐	☐	☐
c.	Social Relationships	☐	☐	☐
d.	Mood	☐	☐	☐
e.	Sleep Patterns	☐	☐	☐
f.	Overall Functioning	☐	☐	☐

3 Since your last visit have you returned to work? Yes ☐ No ☐

If you had injection, did it make improvement in your pain? Yes ☐ No ☐

4 Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life? Yes ☐ No ☐

5 If physical therapy has been a part of your treatment plan:

a. How many sessions have you had? _____

b. Have you missed any sessions? Yes ☐ No ☐

c. If yes, what reason? _____

6 If health psychology has been a part of your treatment plan:

a. How many sessions have you had? _____

b. Have you missed any sessions? Yes ☐ No ☐

c. If yes, what reason? _____

7 Please restate your goals regarding your pain management with us:

_____

8 What goals have you met since your treatment with us?

_____

9 Pattern of pain: (*Please check appropriate)*

What is the frequency of your pain? Constant ☐ Frequent ☐ Occasional ☐

% Time Pain-Free? _____

Does the pain change during the day? Yes ☐ No ☐

If yes, what time of the day is your pain worst? Morning ☐ Afternoon ☐ Night ☐

What part of the day is the pain better? Morning ☐ Afternoon ☐ Night ☐

How many episodes of pain do you have? Per day _____ Per week _____

Duration of episodes: Few minutes ☐ Several hours ☐ Several days ☐

10 Quality of your pain: *(Please check appropriate)*

Burning ☐ Stabbing/Sharp ☐ Dull, Diffused ☐ Cramping/Spasms ☐

Throbbing ☐ Tingling ☐ Numbness ☐ Other _____

11 What areas of pain have improved? _____

12 What areas of pain have stayed the same? _____

13 What areas of pain have gotten worse? _____

14 Any new accidents or falls since your last visit? _____

15 Are you pregnant? Yes ☐ No ☐

16 **Adverse Events:**

Are there any potential side effects from the medications you are taking? *Please check appropriate*

		None	Mild	Moderate	Severe
a.	Nausea	☐	☐	☐	☐
b.	Vomitting	☐	☐	☐	☐
c.	Constipation	☐	☐	☐	☐
d.	Itching	☐	☐	☐	☐
e.	Mental Cloudiness	☐	☐	☐	☐
f.	Sweating	☐	☐	☐	☐
g.	Fatigue	☐	☐	☐	☐
h.	Drowsiness	☐	☐	☐	☐
i.	Other _____	☐	☐	☐	☐

17 Please list all **current** medications:
(Including any **over the counter medications** and **physician prescriptions**)

Name of medication	Dose	Total daily dose	Prescriber