# Follow-up Patient Intake Form

**{Please Print}**

Today's Date: ____/_____/_____

Patients Full Name: _____ DOB: ____/_____/_____

Reason for visit: ☐ Follow-Up ☐ Injection ☐ Post-Procedure Visit

Location of pain: _____

Frequency of Pain: ☐ Continuous ☐ Frequent ☐ Occasional

Quality of Pain:

| | | |
|---|---|---|
| ☐Sharp | ☐Aching | ☐Dull |
| ☐Tingling | ☐Hot-burning | ☐Tight |
| ☐Numb | ☐Stabbing | ☐Pounding |
| ☐Throbbing | ☐Sickening | ☐Cramping |
| ☐Exhausting | ☐Gnawing | ☐Shooting |
| ☐Heavy | ☐Tender | ☐Splitting |

Radiation: ☐ Yes ☐ No If yes, where? _____

Worsening Factors: _____

Strategies used besides medication: _____

Pain level currently {out of 10}: _____

Average pain: _____ Maximum pain: _____ Minimum pain: _____

Pain relieved by taking medications:

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

After starting medication, have your activities: ☐Improved ☐ Remained the same ☐ Decreased

Current function level: ☐ 1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (1 low-10 high)

Quality of sleep: ☐ Good ☐ Fair ☐ Poor Hours of sleep per night? _____

# of times waking up during the night?: _____

Word describing mood: ☐ Good ☐ Fair ☐ Poor

Are you taking your meds as directed? ☐ Yes ☐ No

Do you feel as though your medications provide you with significant benefit? ☐ Yes ☐ No

Are you having any negative side effects from your current medications? ☐ Yes ☐ No

Do you realize that by taking these meds you increase risk of death? ☐ Yes ☐ No

Comments/Questions for the doctor? _____

# Current Symptoms

**Constitutional**

| | | |
|---|---|---|
| Fever | ☐ Yes | ☐ No |
| Chills | ☐ Yes | ☐ No |
| Hot Flashes | ☐ Yes | ☐ No |
| Night Sweats | ☐ Yes | ☐ No |
| Weight Loss | ☐ Yes | ☐ No |

**Cardiovascular**

| | | |
|---|---|---|
| Chest Pain | ☐ Yes | ☐ No |
| Limb Swelling | ☐ Yes | ☐ No |
| Limb pain with walking | ☐ Yes | ☐ No |
| Varicose veins | ☐ Yes | ☐ No |

**Respiratory**

| | | |
|---|---|---|
| Trouble breathing | ☐ Yes | ☐ No |
| Shortness of breath | ☐ Yes | ☐ No |
| Mucus production | ☐ Yes | ☐ No |
| Sleep Apnea | ☐ Yes | ☐ No |
| Wheezing | ☐ Yes | ☐ No |
| Respiratory Infections | ☐ Yes | ☐ No |

**GI**

| | | |
|---|---|---|
| Abdominal pain | ☐ Yes | ☐ No |
| Nausea/vomiting | ☐ Yes | ☐ No |
| Constipation | ☐ Yes | ☐ No |
| Diarrhea | ☐ Yes | ☐ No |

**Musculoskeletal**

| | | |
|---|---|---|
| Muscle Pain | ☐ Yes | ☐ No |
| Cramping | ☐ Yes | ☐ No |
| Muscle Twitch | ☐ Yes | ☐ No |
| Neck Pain | ☐ Yes | ☐ No |
| Back Pain | ☐ Yes | ☐ No |
| Joint Pain | ☐ Yes | ☐ No |
| Joint Swelling | ☐ Yes | ☐ No |
| Joint Stiffness | ☐ Yes | ☐ No |

**Neurologic**

| | | |
|---|---|---|
| Seizures | ☐ Yes | ☐ No |
| Black Outs | ☐ Yes | ☐ No |
| Problems with Memory | ☐ Yes | ☐ No |
| Problems with Concentration | ☐ Yes | ☐ No |
| Headache | ☐ Yes | ☐ No |
| Numbness | ☐ Yes | ☐ No |
| Weakness | ☐ Yes | ☐ No |
| Tremors | ☐ Yes | ☐ No |