Pacific Coast Spine Institute and Pain Center

Patient
Name:_____Date:_____

Follow-Up

What brings you to the office today? O Medication refill O Procedure follow-up O Routine-follow up O New pain problem

Where is the main location of your pain? O Head O Neck O Shoulder O Arm O Upper back O Lower back O Abdomen O Pelvic O Hip O Knee O Leg O Feet

Since your last visit your pain has? O Increased O Decreased O Stayed the same

Since your last visit your pain medication has? O Increased O Decreased O Stayed the same

Since your last visit your activity level has? O Increased O Decreased O Stayed the same

When is your pain worse? O Morning O Afternoon O Night O All the time

Associated with the pain, I also have O Loss of coordination O Loss of dexterity

O Increased sensitivity O Decreased sensitivity

Have you had a change in medication from other doctors? O Yes O No

Constitutional

fatigue O Yes O No
fever O Yes O No
insomnia O Yes O No
loss of appetite O Yes O No

Gastroenterology

diarrhea	O Yes O No
constipation	O Yes O No
nausea	O Yes O No
heartburn	O Yes O No

Psychology

serious depression	O Yes O No
aggression	O Yes O No
hostility	O Yes O No
mood swings	O Yes O No

Cardiology

chest pain (angina)	O Yes O No
dizziness	O Yes O No
shortness of breath	O Yes O No