CLINIC VISIT QUESTIONNAIRE/ PROGRESS NOTE

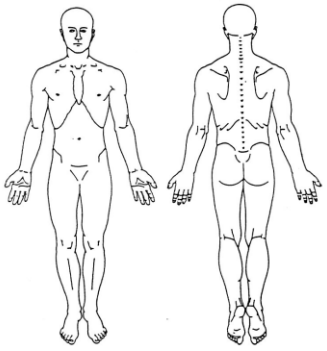
Weight _____
BP _____
Pulse _____
To be completed by clinic

Name _____ **Date** _____

Today I'm seeing: _____

Valid Phone Number: _____ **Pharmacy/Phone:** _____

Shade in the location(s) of your pain:



CHECK ALL THAT APPLY:

PAIN LOCATION(S):

☐ Low back ☐ Neck ☐ Arm (circle Right or Left)
☐ Abdomen ☐ Upper back ☐ Head
☐ Leg (circle Right or Left) ☐ Pelvis ☐ Other: _____

PAIN QUALITY:

☐ Constant ☐ Aching ☐ Burning ☐ Sore
☐ Sporadic/Intermittent ☐ Throbbing ☐ Sharp ☐ Shooting

HAVE THERE BEEN ANY CHANGES IN TYPE, QUALITY, OR LOCATION OF YOUR PAIN SINCE LAST VISIT?

☐ No ☐ Yes *(describe)* _____

PAIN IS WORSE WHEN:

☐ Sitting ☐ Reclining ☐ Standing/Walking ☐ Bending ☐ Other: _____

PAIN IS BETTER WITH:

☐ Heat ☐ Ice ☐ Rest ☐ TENS unit ☐ Other: _____
☐ Injections/Blocks ☐ Medications ☐ Stretching/Exercise ☐ Relaxation/Distraction/Biofeedback

CIRCLE YOUR RESPONSE:

How intense is your pain right <u>now</u>?

0 1 2 3 4 5 6 7 8 9 10

In the last week, your <u>least</u> pain?

0 1 2 3 4 5 6 7 8 9 10

In the last week, your <u>highest</u> pain?

0 1 2 3 4 5 6 7 8 9 10

Since your last visit, is your pain…

Much worse Worse Same Some better Much improved

WHAT PERCENTAGE WOULD YOU ESTIMATE IS YOUR GLOBAL/OVERALL IMPROVEMENT ON YOUR CURRENT TREATMENT PLAN? *(E.G., 0%, 30%, 70%, 100%)* _____

WHAT ACTIVITIES ARE YOU ABLE TO <u>DO</u> NOW AS A RESULT OF YOUR PAIN TREATMENT REGIMEN? *(E.G., ATTEND CHURCH, PLAY WITH KIDS, CONTINUE JOB, CLEAN HOUSE)*

_____

CHECK ALL THAT APPLY:

PROBLEMS SINCE YOUR LAST VISIT?

☐ Fever ☐ Constipation
☐ Fatigue ☐ Jaundice
☐ Chest pain ☐ Weight gain
☐ Palpitations ☐ Weight loss
☐ Light headed ☐ Anxiety
☐ Dizziness ☐ Depression
☐ Edema/swelling ☐ Memory loss
☐ Cough ☐ Poor sleep
☐ Wheezing ☐ Excessive drowsiness
☐ Shortness of breath at rest
☐ Shortness of breath with exertion
☐ Snoring ☐ Itching
☐ Heartburn ☐ Rash
☐ Nausea ☐ Sweating
☐ Vomiting ☐ Urinary changes
☐ Diarrhea

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (FROM ANY DOCTOR) AND WHAT THEY ARE FOR:
(e.g., Lortab 7.5mg, 4x/day for pain; Ambien 12.5mg at bedtime for sleep; Prilosec once a day for reflux)

Space reserved for doctor notes

	No	Yes	Notes
ANY MEDICAL OR DENTAL VISITS SINCE YOUR LAST VISIT?			*List reason, name of provider, any new health issues or treatments started:*
ANY CHANGES TO FAMILY OR SOCIAL HISTORY SINCE YOUR LAST VISIT?			*Please list new information (e.g., marriage, children, employment change):*
ARE YOU DOING A WALKING, STRETCHING, OR POOL PROGRAM REGULARLY?			*If yes, explain what type of exercise and how many hours per week of physical activity:*

***HAVE YOU ATTENDED OR WATCHED ANY OF THE 6 PAIN CLASSES HERE?** ☐ No ☐ Yes

***HAVE YOU SEEN THE PHYSICAL THERAPIST HERE IN THE PAST YEAR (DR. TURMAN)?** ☐ No ☐ Yes

***HAVE YOU SEEN DR. DOLEYS, DR. DOLCE, OR DR. CIANFRINI WITHIN THE PAST YEAR?** ☐ No ☐ Yes

CHECK *ALL* OF THE FOLLOWING THAT APPLY TO YOU SINCE YOUR LAST CLINIC VISIT:

☐ I have taken my medicine *exactl*y as prescribed ☐ I have taken *more* medicine than prescribed

☐ I have skipped or forgotten medicine doses ☐ I have used alcohol

☐ I have used recreational drugs (e.g., pot) ☐ I have smoked cigarettes

(*If so, how many packs per day?*) _____

Please list the 1-3 most important thing(s) to discuss with your doctor today:

1.

2.

3.