

PALM BEACH PAIN CONSULTANTS

FOLLOW UP VISIT

NAME: _____

DATE: _____

Reason for Visit: _____

Medications: _____

Pain Score (1-10): _____ (Current Pain Level)

Please circle all that apply:

1. Constitutional:

Fever, Chills, Night sweats, Fatigue, Change in body weight,
Change in sleep

2. Cardio Vascular:

Chest pain, Palpitations, Shortness of breath with exertion

3. Gastrointestinal:

Pain or difficulty with urination, Increased frequency or urgency, Blood in urine

4. Musculoskeletal/ Rheumatologic:

Swelling of the joints or muscles, Morning stiffness, Tender joints or muscles

5. Dermatologic:

Rashes or Bruises

6. Psychiatric:

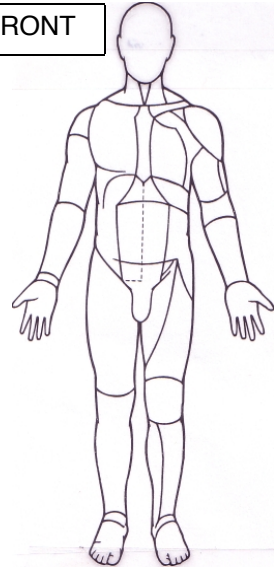
Change in appetite, Unusual stress, Feeling sad or depressed,
Thinking of harming yourself or anyone else, Anxiety

7. Neurologic:

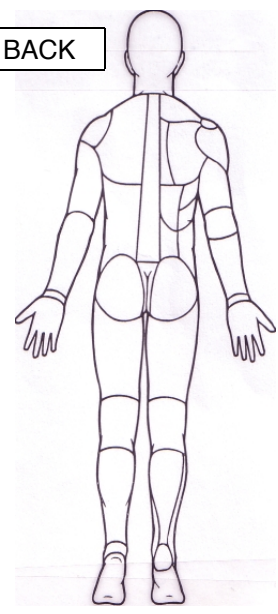
Weakness, Tingling or change in sensation in one or more limbs,
Fallen or loss of Consciousness, Seizures

PAIN DIAGRAM
Please mark the EXACT area of pain on the pictures below

FRONT



BACK



Are You Currently Working? **Yes/No**(circle) If **yes**, How many hours/week _____

How Many hours per day do you spend out of Bed on Average? _____

List activities you perform outside of work: _____

List activities you enjoy: _____

How many hours per week do you engage in enjoyable activity? _____

Do you think your pain treatment helps you work or engage in other activities? **Yes/No**

Do you think your pain treatment helps you to sleep better? **Yes/No** (circle)

Do you feel your pain is improved since starting pain treatment? **Yes/No** (circle)

Please list any changes in your health or your medical history since your last visit with us:

Please list any questions or comments that you have: _____

Wayne Weidenbaum, M.D.