PALM BEACH PAIN CONSULTANTS

FOLLOW UP VISIT

NAME: _____ DATE: _____

Reason for Visit: _____

Medications: _____

_____

_____

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

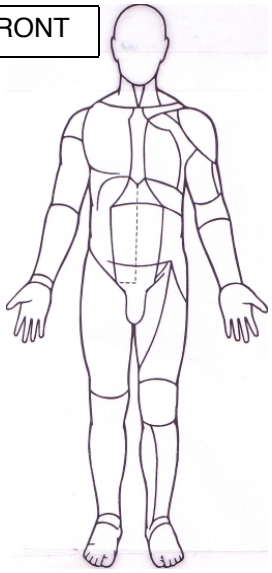
PAIN DIAGRAM

Please mark the EXACT area of pain on the pictures below

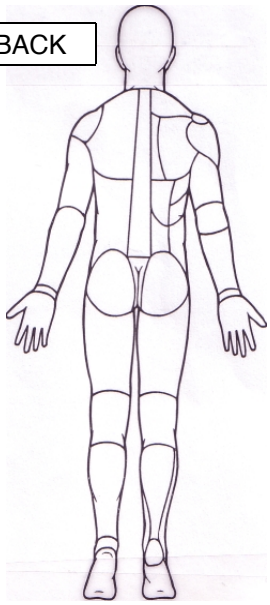
Please circle all that apply:

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

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.