Follow-up Visit Intake Paperwork

DIAGNOSTIC PAIN CENTER

Please carefully complete all sections of this form, even if nothing has changed since your last visit.

Your Name:______________________________Date of Birth:______________Today Date: ______________

Has your medical coverage changed from your last visit?❑ Yes ❑ No

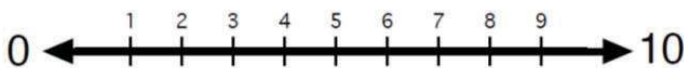
Reason For Today's Visit

❑ Medication Refill ❑Medication Change ❑ Post-Procedure Assessment ❑Review MRI Results

❑ Review Test Results ❑Other: ____

Pain Description

Height:_____________Weight: _______________



Please rate your pain using a 0 - 10 scale:

______ Your pain right now?

______ Your worst pain?

______ Your least pain?

______ Your average pain over the last month?

Where is your worst area of pain located?

____

Does this pain radiate? If so, where?

____

Check all that describe your pain today:

❑Aching ❑Shooting

❑Cramping ❑Spasms

❑Dull ❑Squeezing

❑Tingling/Pins and Needles

❑ Hot/Burning ❑ Tiring/Exhausting

❑Numb ❑ Stabbing/Sharp

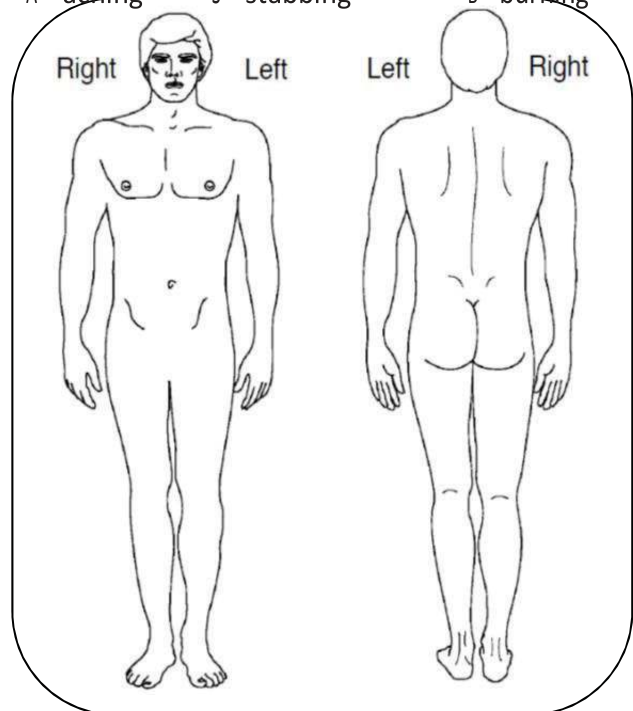
❑Shock-like ❑Throbbing

Use the diagram to indicate the location and type of your pain.

Mark the drawing with the following letters that best describe your symptoms:

N = numbness P = pins and needles

A = aching S = stabbing B = burning



What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

❑ Enjoyment of Life ❑ Normal Work ❑ Sleep
❑ General Activity ❑ Recreational Activities ❑ Walking
❑ Mood ❑ Relationships with People ❑ Other: ______________________

Changes Since your Last Visit

Have you developed any new pain complaints since your last visit you would like to discuss today? ❑ Yes ❑ No

Since your last appointment, how as your pain changed? ❑ Decreased ❑ Increased ❑ Stayed the same

If you had a procedure, how much pain relief did you obtain?

❑ None ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

Were there any problems? ❑ Yes ❑ No If yes, please explain: ______________________________________

Since your last visit, have you developed any new:

❑ Balance Problems ❑ Bladder incontinence ❑ Bowel incontinence ❑ Chills
❑ Difficulty Walking ❑ Fevers ❑ Nausea ❑ Vomiting
❑ Numbness/Tingling – Where? ____________________ ❑ Weakness – Where? ________________________
❑ New **ALLERGIES** to medications ❑ **New hospitalizations, studies or health issues**

❑ I HAVE NOT RECENTLY DEVELOPED PROBLEMS WITH ANY OF THE ABOVE CONDITIONS SINCE MY LAST VISIT.

Current Medications

Please list any *changes* since your last visit in the medications you are currently taking.

Medication Name	Dose	Change

Are you currently taking any blood-thinners or anticoagulants? ❑ Yes ❑ No

Medications Effects

Mark the following medication side-effects you are experiencing, if any:

❑ Confusion ❑ Constipation ❑ Dizziness ❑ Drowsiness
❑ Dry Mouth ❑ Nausea ❑ Vomiting ❑ Weight Gain

❑ I do not have any adverse side effects from current medications.
❑ I am stable on my current medication regimen.
❑ My medications help to improve my functioning and quality of life.

Medical and Surgical History

Please list any *changes* since your last visit in your medical or surgical history: ❑ No Changes

____

____

____

____

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional: ❑ Chills ❑ Difficulty Sleeping ❑ Easy Bruising
❑ Excessive Sweating ❑ Excessive Thirst ❑ Fatigue ❑ Fevers
❑ Insomnia ❑ Low Sex Drive ❑ Night Sweats ❑ Tremors
❑ Unexplained Weight Gain ❑ Unexplained Weight Loss ❑ Weakness

Eyes: ❑ Recent Visual Changes

Ears/Nose/Throat/Neck: ❑ Dental Problems ❑ Earaches ❑ Hearing Problems
❑ Nosebleeds ❑ Recurrent Sore Throats ❑ Ringing in the Ears ❑ Sinus Problems

Cardiovascular: ❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis
❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness
❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Respiratory: ❑ Cough ❑ Wheezing ❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort ❑ Shortness of Breath at Rest

Gastrointestinal: ❑ Abdominal Cramps ❑ Acid Reflux ❑ Constipation
❑ Coffee Ground Appearance in Vomit ❑ Dark and Tarry Stools ❑ Diarrhea
❑ Hernia ❑ Vomiting

Musculoskeletal: ❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness
❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Genitourinary/Nephrology: ❑ Blood in Urine
❑ Decreased Urine Flow/Frequency/Volume ❑ Flank Pain ❑ Painful Urination

Neurological: ❑ Carpal Tunnel Syndrome ❑ Dizziness
❑ Headaches ❑ Numbness/Tingling ❑ Instability When Walking ❑ Tremors ❑ Seizures

Psychiatric: ❑ Depressed Mood ❑ Feeling Anxious ❑ Stress Problems
❑ Suicidal Thoughts ❑ Suicidal Planning

Signature and Date

I authorize Diagnostic Pain Center (DPC) and any associates, assistants and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. Additionally, I acknowledge that DPC will access the Texas DPS website in regards to prescription medications.

I hereby assign any/all medical and/or surgical benefits to which I am entitled through Medicare, Medicaid, Worker's Compensation, Letter of Protection, or any other governmental or private insurance or health plans to Diagnostic Pain Center. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

Signed:____ Date: _________________________