Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

FOLLOW UP FORM

PATIENT NAME: _____ DATE: _____

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS:

1. What is the purpose of your visit today?

☐ New complaint ☐ Follow up after a procedure.

☐ Medication refill ☐ Re-Check

☐ Other: _____

2. Where is your worst pain today (pick one body area you would like addressed today)?

3. Have we seen you for this body area before? ☐ **Yes** ☐ **No,** this is a new body area

4. Have you had a procedure performed on this area? ☐ **Yes** ☐ **No** If yes date _____

5. Did you experience any complications from procedure? ☐ **Yes** ☐ **No**

   If yes,explain_____

   _____

   _____

6. Please indicate the % of improvement from procedure _____%

7. Does that pain radiate? ☐ **Yes** ☐ **No** If so, to where does it radiate? _____

8. Rate the Severity of your pain on a scale of 0 - 10.

☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐ **8** ☐ **9** ☐ **10**

9. Is your pain overall getting better, worse, or staying the same? _____

10. Describe your pain using 3 or 4 words (aching, tingling, throbbing, shooting, etc.)?_____

11. What makes the pain worse (activity, bending, standing, lifting, etc.)?

    _____

12. What makes the pain better (stretching, ice, heat, rest, medications, etc. or nothing)?

    _____

Integrated Spine, Pain & Wellness

DR. ASHU GOYLE

13. Are you taking pain medications to manage the pain? ☐ **Yes** ☐ **No** If yes, which medications:
_____
_____

14. Have there been any significant changes to your health since we last saw you? ☐ **Yes** ☐ **No** If yes please describe _____

15. Have you undergone any other surgeries or started/stopped any medications since we last saw you? ☐ **Yes** ☐ **No** if yes please describe: _____

REVIEW OF SYSTEMS

16. **Constitutional:** ☐ None ☐ Fevers ☐ Night sweats ☐ Chills

17. **Cardiac:** ☐ None ☐ Chest pain ☐ Palpitations ☐ Shortness of Breath

18. **GI:** ☐ None ☐ Constipation ☐ Nausea ☐ Vomiting ☐ Acid reflux

19. **Neurological:** ☐ None ☐ Sedation ☐ Numbness ☐ Weakness
☐ NEW bowel or bladder incontinence ☐ Suicidal thoughts/planning

COMMENTS:

_____

_____

Reset Save Print