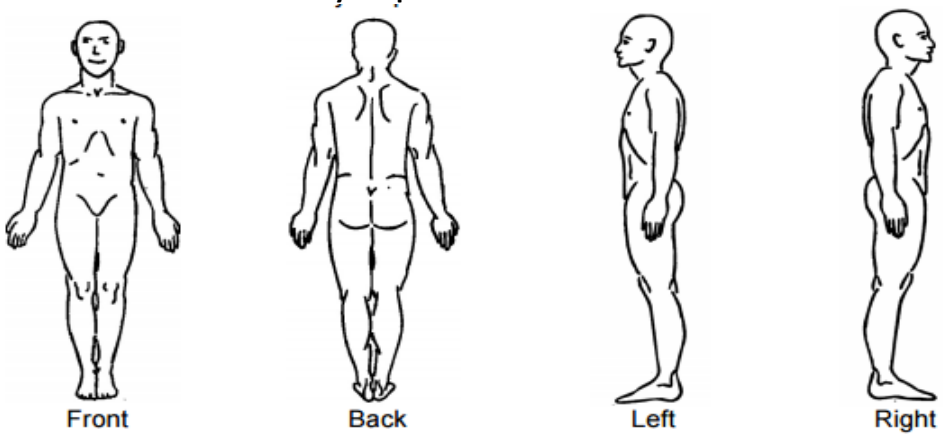
FOLLOW-UP PATIENT VISIT FORM

Patient Name:	Date of Birth:	Provider:

1. **Please shade the location of your pain:**



Circle all that apply:

Fevers/Chills
Cancer Diagnosis
Active Infection
Blood Thinners
Bleeding Disorder
Pacemaker/ICD
Arrhythmia
Liver Disease
Suicidal Thoughts
Homicidal Thoughts
Bladder Incontinence
Balance Problems
Nausea
Vomiting

2. **How do you describe your pain?**

☐Aching ☐Hot/Burning ☐Shooting ☐Stabbing/Sharp
☐Cramping ☐Numbness ☐Spasming ☐Throbbing
☐Dull ☐Shock-like ☐Squeezing ☐Tingling/Pins & Needles

3. **Name of procedure performed on your last visit, if any _____**
   - **If yes, did you notice any relief?** ☐Yes ☐No
   - **If yes, what percent relief did you notice? _____% for how long? _____**
   - **Did you have any side effects from your last procedure?** ☐Yes ☐No
   - **What was the side effect? _____**

4. **On a scale of 0 (no pain) to 10 (worse pain possible), what is your pain level:**
   Now: _____ Best: _____ Worst: _____ Average: _____

5. **What makes your pain worse?**

☐Laying down ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lifting ☐Doing home chores ☐Weather changes

6. **What makes your pain better?**

☐Rest ☐Heat/Ice ☐Medications ☐Laying down ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lifting

7. **Since your pain began, how has it changed?** ☐Decreased ☐Increased ☐Stayed the same

Visitors are not permitted to Record without prior consent. Mercy Pain Management does NOT consent to any form of recording. Recording includes audio, video, photography, and audio recordings. Please avoid the use of any electronic devices during your visit or phone calls with our office. Anyone who violates this policy may be subject to dismissal from our clinic.

PATIENT SIGNATURE _____ **DATE** _____

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Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: *This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).*

No Disability 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Recreation: *This disability includes hobbies, sports, and other similar leisure time activities.*

No Disability 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Social Activity: *This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.*

No Disability 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Occupation: *This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.*

No Disability 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Sexual Behavior: *This category refers to the frequency and quality of one's sex life.*

No Disability 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Self-Care: *This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)*

No Disability 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Life-Support Activities: *This category refers to basic life supporting behaviors such as eating, sleeping and breathing.*

No Disability 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ Worst Disability

Rate your pain with activity NO PAIN 0__ 1__ 2__ 3__ 4__ 5__ 6__ 7__ 8__ 9__ 10__ VERY SEVERE PAIN

Signature: _____ Date: _____