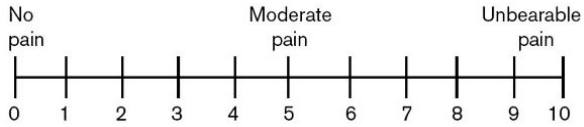
Spine Follow-Up

Patient sticker

What is the primary problem that brings you for follow-up?	Overall, have your symptoms: ☐ Improved ☐ Worsened ☐ Not sure

Circle a number from 0-10 that best describes how much pain you have had on average for the last week:



For a child or non-english speaking adult, use the FACES© pain rating scale below:

Since we last saw you, have you had:

☐ Fever ☐ Chills ☐ Night sweats ☐ Unintentional weight loss

☐ New weakness

(Where: _____)

☐ New numbness (including groin/genitals)

(Where: _____)

☐ Difficulties with hand coordination

☐ Difficulties with balance

☐ Falls (When: _____ How: _____)

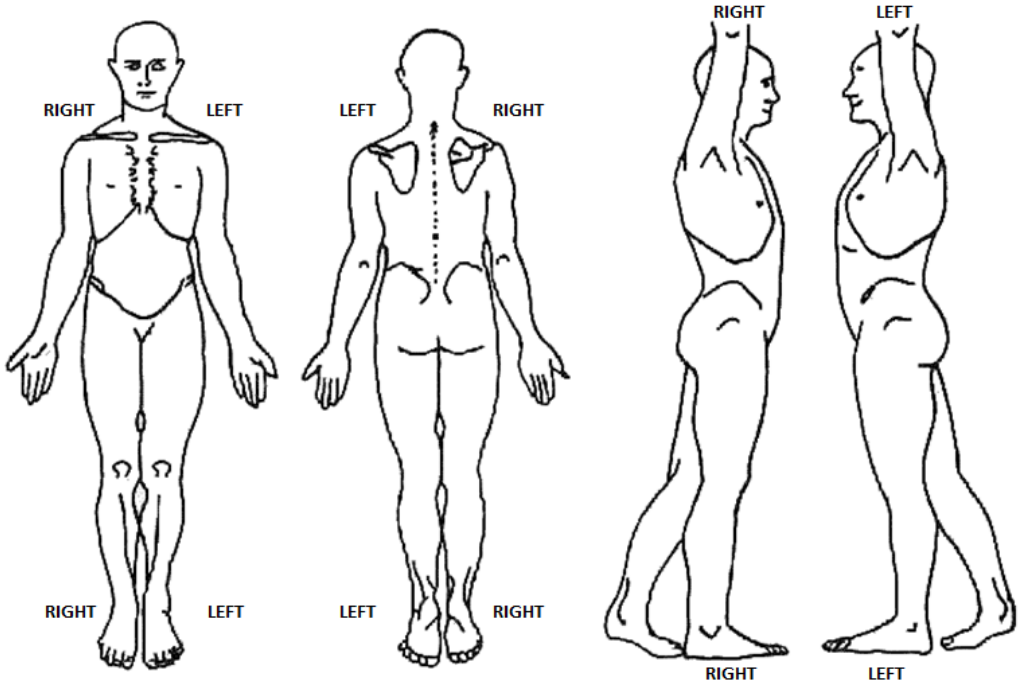
☐ **Losing control of bowel**

☐ **Losing control of bladder**

Please mark any **area(s) of symptoms** on the adjacent drawings accordingly:

Pain
Use 'x' for pain

Sensory Changes
Use 'o' for numbness/tingling



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Have you seen any of the following professionals for your current symptoms?

☐ Primary care ☐ Physiatrist ☐ Chiropractor ☐ Neurologist ☐ Psychologist/ Psychiatrist
☐ Surgeon ☐ Pain Management ☐ Physical Therapist ☐ Other:_____

What **Medications** for pain have you tried? **Circle or write in ones tried.**	What was your response?
☐ **Anti-inflammatory medications** e.g., acetaminophen (Tylenol), ibuprofen (Advil, Motrin), naproxen (Aleve), Celebrex, meloxicam (Mobic) diclofenac, nabumetone (Relafen)	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Muscle relaxants** e.g., cyclobenzaprine (Flexeril), tizanidine (Zanaflex), carisoprodol (Soma), methocarbamol (Robaxin), metaxalone (Skelaxin), baclofen, clonazepam (Klonopin), diazepam (Valium)	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Opioid medications** e.g., tramadol (Ultram), codeine, hydrocodone (Vicodin, Norco), oxycodone (Percocet, Oxycontin), morphine, fentanyl, Dilaudid	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Nerve pain medications** e.g., gabapentin (Neurontin), pregabalin (Lyrica), nortriptyline, amitriptyline, duloxetine (Cymbalta), Topamax, mexiletine	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Anti-depressant pain medications** e.g., amitriptyline (Elavil), fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), citalopram (Celexa), duloxetine (Cymbalta), trazodone	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Oral steroids** e.g., methylprednisolone (Medrol), prednisone	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
☐ **Other**	☐ Yes, it has helped ☐ No, it has not ☐ Not sure Side effects:
What **Therapies** have your tried?	What was your response?
☐ **Physical Therapy** | Weeks completed: _____ ☐ **Physical Modalities** – ultrasound, electric stimulation, TENS ☐ **Heat / Ice** ☐ **Chiropractic / Manipulations** ☐ **Massage** ☐ **Bracing** ☐ **Traction**	☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure
☐ **Spinal Injections. Circle or write in ones tried.** epidural steroid injections, facet joint injections, sacroiliac joint injections, medial branch blocks, radiofrequency lesioning **Dates:** _____	☐ Yes, it has helped ☐ No, it has not ☐ Not sure
☐ **Acupuncture** ☐ **Yoga** ☐ **Pilates** ☐ **Meditation** ☐ **Biofeedback** ☐ **Psychology / Cognitive Therapy**	☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure ☐ Yes, it has helped ☐ No, it has not ☐ Not sure

What treatments might you be interested in at this time?

☐ Medications ☐ Physical Therapy ☐ Chiropractor ☐ Acupuncturist ☐ Psychology/ Psychiatry
☐ Injections ☐ Pain Management ☐ Surgery ☐ Other:_____

Spine Follow-Up

Review of Systems:	
Circle and explain if you have any of the following:	Comments
☐ Fever, chills, weight loss/ gain, malaise/ fatigue, sweats	_____
☐ Rash, itching	_____
☐ Hearing loss, ringing in ear, ear pain, ear discharge, nosebleeds, congestion, sinus pain, high pitched wheeze, sore throat	_____
☐ Blurred/ double vision, light sensitivity, eye pain/ discharge, eye redness	_____
☐ Chest pain, palpitations, short of breath when flat, poor circulation in legs, leg swelling, short of breath at night, vascular disease	_____
☐ Cough, coughing up blood, sputum, shortness of breath, wheezing	_____
☐ Heartburn, nausea, vomiting, abdominal pain, diarrhea, constipation, blood in stool, dark stool	_____
☐ Painful urination, urgency, frequent urination, blood in urine, flank pain	_____
☐ Muscle ache/ pain, neck pain, back pain, joint pain, falls	_____
☐ Easy bruising/ bleeding, allergies, excess thirst, diabetes, thyroid problems, endocrine problems	_____
☐ Dizziness, headaches, tingling, tremor, sensory change, speech change, focal weakness, general weakness, seizures, loss of consciousness	_____
☐ Depression, suicidal ideas, substance abuse, hallucinations, anxiety, difficulty sleeping, memory loss	_____