

FOLLOW-UP QUESTIONNAIRE

Name: _____ **Age:** _____
Last First Middle Initial

Date: ____/____/200____ **Height:** ____ft____in **Weight:** _____lbs

Last Procedure Date: ____/____/____ **Primary Treating M.D.:** _____

(circle one)

1. Since my last visit, my Back / Leg and Neck/ Arm symptoms are:

- Unchanged
- Improved, describe: _____
- Worsened, describe: _____

2. Which of the following therapies have you tried since your last visit?
 (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Pain pills (e.g., Tylenol with Codeine, Darvocet, etc.) | <input type="checkbox"/> Antidepressants (e.g., Elavil, Prozac, etc.) |
| <input type="checkbox"/> Chiropractic/Osteopathic Manipulations | <input type="checkbox"/> Physical Therapy, Describe: _____ |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Injections, Describe: _____ |
| <input type="checkbox"/> Muscle Relaxants (e.g., Flexeril, etc.) | <input type="checkbox"/> Other, Describe: _____ |
| <input type="checkbox"/> Anti-inflammatories (e.g., Motrin, Advil, Alleve, etc) | |

3. Have you had surgery since your last visit?

- No
- Yes, complete the following:

Date	Surgery Type (Please provide details.)	Change in condition after Surgery. (circle one)
		Same Better Worse for _____ months.

4. Have you had any of the following tests since your last visit?

- | | <i>Approx. Date</i> | <i>Results (If Known)</i> |
|------------------------------------|---------------------|---------------------------|
| <input type="checkbox"/> MRI Scan | _____ | _____ |
| <input type="checkbox"/> CT Scan | _____ | _____ |
| <input type="checkbox"/> Myelogram | _____ | _____ |
| <input type="checkbox"/> Discogram | _____ | _____ |
| <input type="checkbox"/> EMG Test | _____ | _____ |
| <input type="checkbox"/> Other | _____ | _____ |

5. Who is the primary physician that is treating you for you spine condition? _____

6. What is your understanding of the current treatment plan? _____

7. Please place a mark on the line at the point that represents your level of pain **TODAY**.

No |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Worst Possible Pain
Pain

8. Please place a mark on the line at the point that represents your level of pain **IN THE LAST WEEK**.

No |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| Worst Possible Pain
Pain

9. Are you currently working?

YES (choose the **ONE** answer that best describes your current work situation)

- I have the exact same job since I started having symptoms
- I have the same job, but it was modified or the hours were reduced because of my symptoms
- I have changed jobs because of my symptoms
- I have changed jobs, but for reasons unrelated to my symptoms

NO (please answer the following)

a. I have been off work for _____year(s)_____month(s)_____week(s)

Questions # 10 - 13 apply **only if you have had an injection procedure**. If you have seen us for a consultation only, and have not had a procedure, please go to question # 14.

10. Did you have a flare-up after your procedure?

Yes

How long did it last? _____ How severe was it? 0 – 10 scale _____

No

11. Please check the statement that you feel best applies to your attitude toward the procedure you had.

- The treatment met my expectations
- I did not improve as much as I had hoped, but I would undergo the same treatment for the same outcome.
- The treatment helped, but I would not undergo the same procedure for the same outcome.
- I am the same or worse than before the treatment.

12. How would you rate the pain for which you had the procedure? (please check one)

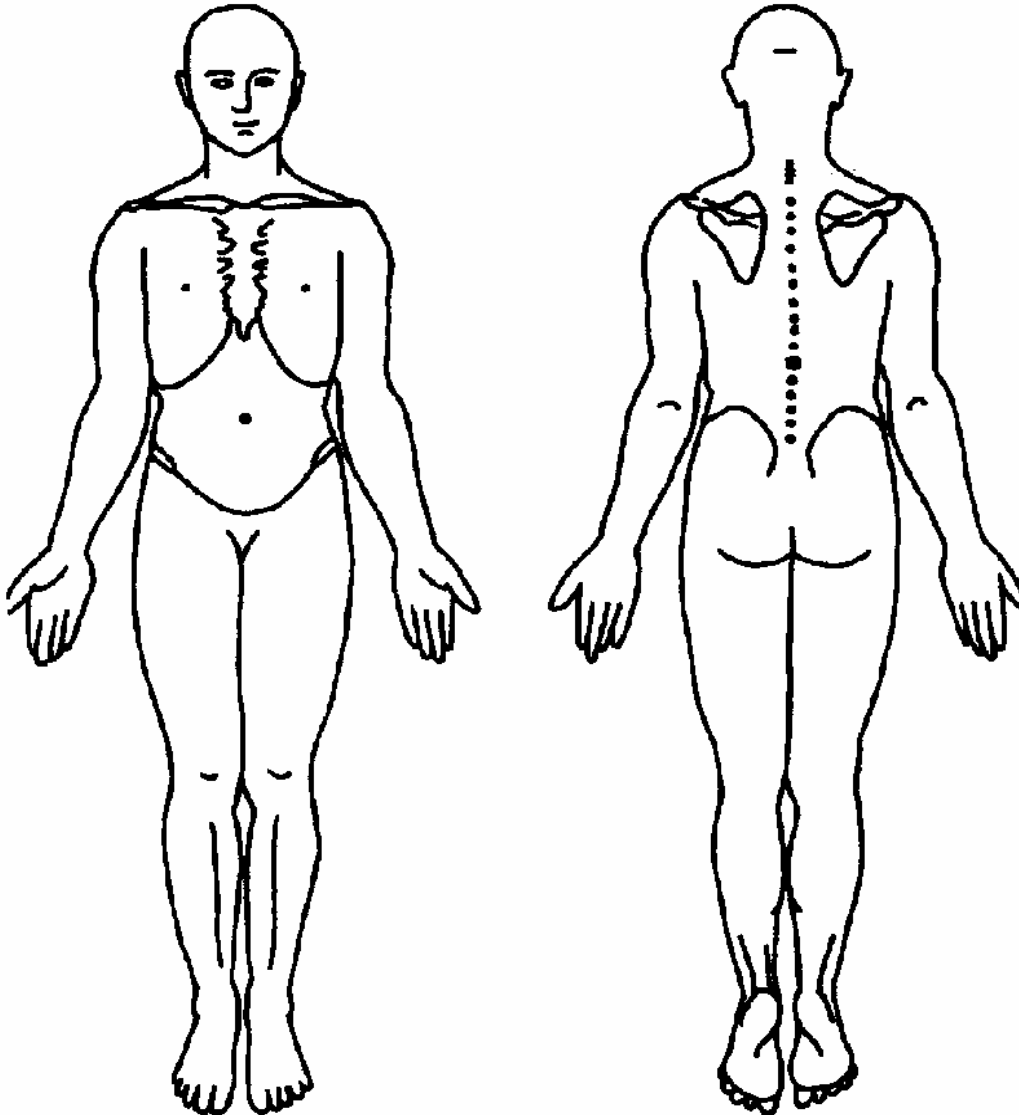
- Much Better
- Better
- Same
- Worse
- Much Worse

13. Which of the following best describes your current general overall activity level in comparison to before the procedure? (please check one)

- Much Better
- Better
- Same
- Worse
- Much Worse

17. Please mark the location(s) of your pain on the body outlines using the symbols below.

OOO Pins & OOO Needles	///// Stabbing /////	XXX Burning XXX
=== Numbness ===	AAAA Aching AAAA & Cramping	+++ Other Sensations +++



CHECK THE MOST APPLICABLE

- back and legs hurt about the same
- low back hurts much more than legs
- low back hurts somewhat more than legs

OR

- neck hurts much more than arms
- neck and arms hurt about the same
- neck hurts somewhat more than arms

Does not need to equal 100 %

(circle one)
My **Back or Neck pain** is _____ %
Better Worse Same (circle one)

(circle one)
My **Leg or Arm pain** is _____ %
Better Worse Same (circle one)

*** SPECIFY BETTER/WORSE/SAME

18. Pain medication in the last week: *(please circle one)*

None	Occasional Non Narcotic	Daily Non Narcotic	Occasional Narcotic	Daily Narcotic
1	2	3	4	5

19. During the past week, how much did pain interfere with your normal work (including both work outside the home and housework)? *(please circle one)*

Not at all	A little bit	Moderately	Quite a bit	Extremely
1	2	3	4	5

20. If you had to spend the rest of your life with your present pain condition, how would you feel about it? *(please circle one)*

Very satisfied	Somewhat satisfied	Neutral	Somewhat dissatisfied	Very dissatisfied
1	2	3	4	5

21. During the past 4 weeks, about how many days did you cut down on the things you usually do for more than half the day because of your pain? *(please circle one)*

0-5 (days)	6-11 (days)	12-17 (days)	18-23 (days)	24-28 (days)
1	2	3	4	5

22. During the past 4 weeks how many days did your pain keep you from going to work or school? *(please circle one)*

0-5 (days)	6-11 (days)	12-17 (days)	18-23 (days)	24-28 (days)
1	2	3	4	5

23. During the past week, how bothersome have each of the following symptoms been? *(please circle one)*

	Not at all bothersome	Slightly bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
Low back/Neck pain	1	2	3	4	5
Leg /Arm pain	1	2	3	4	5

Staff use only: _____