



Interventional Follow - Up: History

Name: _____ Date: ___/___/___

What **improvement** can you report following your injection? (circle one)

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

Have you had any **worsening** of your arm or leg weakness immediately following the injection? Yes No

Are you having any **new** weakness, numbness/tingling immediately following your injection? Yes No

What pain medications are you taking? _____

Have you been able to use less medication since the injection? _____

Have you been more active exercising since the injection? _____

Describe your pain (circle those that apply):

A. Neck – Sharp - Burning – Shooting – Achy - Knife-Like - Twisting
Pressure - Lancinating - Tooth-Ache - Deep - Heavy - Gnawing

Do you have any **new** weakness or pain shooting down your arm? No Yes. If yes, describe _____

B. Mid Back – Sharp - Burning – Shooting – Achy - Knife-Like - Twisting
Pressure - Lancinating - Tooth -Ache - Deep - Heavy - Gnawing

C. Low Back – Sharp - Burning – Shooting – Achy - Knife -Like - Twisting
Pressure - Lancinating - Tooth -Ache - Deep - Heavy - Gnawing

Do you have any weakness or pain shooting down your leg? No Yes If yes, describe _____

D. Other – i.e. Shoulder, Knee, Elbow, Wrist, _____

NEW HISTORY

Are you taking any **New** medications since **last visit**? _____

Any **New** medication allergies or other allergies since **last visit**: _____

Any **New** illnesses, injuries, surgeries or hospitalizations since **last visit**: _____

Is there a chance you are pregnant? yes no

Any change in your FAMILY HISTORY since your **last visit** (parents, siblings, children, grandparents)? _____

Any change in your SOCIAL HISTORY since our **last visit** (marital status, employment, drugs, alcohol, tobacco, education)? _____

Circle any **NEW** symptoms since last visit.

- **Constitutional** : chills – fatigue – weight loss or gain – daytime sleepiness
- **Eyes** : eye pain/pressure – vision changes
- **Ears, Nose, Throat** : ringing in ears – hearing loss – dizziness - sinus pain – sore throat - snoring
- **Cardiovascular** : chest pain – palpitations – ankle swelling – wake short of breath
- **Respiratory** : cough - wheezing – shortness of breath – coughing up blood
- **Gastrointestinal** : trouble swallowing – abdominal pain – bowel irregularity
heartburn – nausea/vomiting – rectal bleeding
- **Genitourinary** : painful urination - blood in urine - frequent urination
prostate problems – loss of bladder control
- **Musculoskeletal** : joint aches - muscle aches
- **Skin** : rash - itching - hives - skin or hair changes
- **Neurological** : passing out - headache - weakness - numbness/tingling - memory loss - seizures
- **Psychological** : depression - anxiety/panic - nervousness – mood changes - tension
- **Endocrine** : feeling warmer than others - feeling cooler than others
- **Hematology/Lymphatics** : easy bruising - bleeding problems - sweating at night – swollen glands
- **Allergies**: environmental allergy – sneezing fits



Review of Systems
I have reviewed with the patient and everything not circled is unchanged from last visit, unless noted in history
Doctor Initials _____

Do you feel that formal rehab therapy has helped? yes no Not attending since last visit

Do you feel that chiropractic care has helped? yes no Not attending since last visit

Reviewed by Doctor/PA (Initials) _____

Follow -Up History Name: _____ **Date:** ____/____/____

Your level of pain - please circle number

<u>Your pain right now</u>				
no pain 0	tolerable no pain meds 1 - 2 - 3	need to take medicine 4 - 5 - 6	take narcotics go to the ER 7 - 8	admit to the hospital 9 - 10
<u>Your average pain</u>				
no pain 0	tolerable no pain meds 1 - 2 - 3	need to take medicine 4 - 5 - 6	take narcotics go to the ER 7 - 8	admit to the hospital 9 - 10
<u>Your worst pain</u>				
no pain 0	tolerable no pain meds 1 - 2 - 3	need to take medicine 4 - 5 - 6	take narcotics go to the ER 7 - 8	admit to the hospital 9 - 10

FUNCTION: Since your last visit how much has your pain interfered with your life:

1. **Ability to work:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
2. **Ability to sleep:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
3. **Ability to participate in social activities:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
4. **Ability to do household chores:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
5. **Relationship with family:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
6. **Sexual activities:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
7. **General Mood:**
Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes
8. Do you need to lie down during the day due to pain? Yes No
9. If so, please circle how many times on average you need to lie down during the day. 1 2 3 4
10. Do you wake up during the night because of pain? Yes No
11. Do you feel rested in the morning? Yes No
12. Please circle the average number of hours you sleep at night?
0 1 2 3 4 5 6 7 8 9 10

MEDICATIONS

1. Please write any medications that you may be on and write the daily dosage: _____

2. Side Effects: Please circle if you have any of the following side effects:

- Constipation - Sedation - Nausea/Vomiting - Trouble Urinating - Trouble Sleeping
Swelling - Feeling Bad - Trouble Thinking - Sexual Problems

Doctor's Notes:

Reviewed by Doctor/PA (Initials) _____

2006 Foulk Rd, Suite B, Wilmington, DE 19810 ~ 302-529-8783 + 700 Lea Blvd, Suite 102, Wilmington, DE 19802 ~ 302-529-8783
87B Omega Drive, Newark, DE 19713 ~302-733-0980 + 29 North East St, Smyrna, DE 19977 ~302-389-2225
2600 Glasgow Ave, Suite 210, Newark, DE 19702 ~ 302-832-8894 + 2150 New Castle Ave, New Castle, DE 19720 ~ 302-529-8783
200 Banning Street, Suite-350, Dover, DE 19904 302-730-8848

