FK RH NC OM GW SM EH ___W/C ___ PIP ___Health

Form 5 - Revised: 06/15/2010

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

Your pain right now

no pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to the hospital
0	1 - 2 - 3	4 - 5 - 6	7 - 8	9 - 10

Your average pain

no pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to the hospital
0	1 - 2 - 3	4 - 5 - 6	7 - 8	9 - 10

Your worst pain

no pain	tolerable no pain meds	need to take medicine	take narcotics go to the ER	admit to the hospital
0	1 - 2 - 3	4 - 5 - 6	7 - 8	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: _________________________

____

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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:

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Reviewed by Doctor/PA (Initials) ________

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