Confluence HEALTH

Physiatry Follow-Up

Physical Medicine and Rehabilitation

Scan into Medical Record; discard after electronic entry

PLACE LABEL HERE, IF AVAILABLE
IF NOT, FILL IN FOLLOWING INFORMATION:

PATIENT NAME: _____

HISTORY NUMBER: _____

PATIENT DATE OF BIRTH: _____

LOCATION OF SERVICE: _____

DATE OF SERVICE: _____

***Overall*, is your pain:**

☐ Getting better ☐ Getting worse ☐ Staying about the same ☐ Significantly variable

How would you describe your pain?

☐ Ache / Throb ☐ Sharp / Stab ☐ Stiffness ☐ Burn ☐ Numbness ☐ Tingling

Does this pain affect activities of daily living, such as dressing, working, walking, sleeping, hygiene, etc.? ☐ Yes ☐ No

Please rate current function level at home: 1 2 3 4 5 6 7 8 9 10

10 = severe impact on function at home; 0 = level of function prior to injury

PAIN SEVERITY

1. **If 10 is the worst pain imaginable, and 0 is no pain, please note your pain over the last TWO WEEKS:**
   a. Please range your WORST pain.
   0 1 2 3 4 5 6 7 8 9 10
   b. Please rate your LEAST pain.
   0 1 2 3 4 5 6 7 8 9 10
   c. Please rate your overall or AVERAGE pain.
   0 1 2 3 4 5 6 7 8 9 10
2. **Over an average week, how many days do you have your usual pain?**
   0 1 2 3 4 5 6 7
   a. Over an average day, how many hours do you have your usual pain?"
   ☐ Less than 1 hour ☐ 1-4 hours ☐ 4-8 hours
   ☐ Most daytime hours ☐ Almost 24 hours/day
3. If you have NIGHT pain, does it awaken you at night?
   ☐ Yes ☐ No
4. Have you had **any of these symptoms** as part of your current symptoms? If yes, please check in the box below.

   ☐ Weakness
   ☐ Loss of control of bladder or bowel
   ☐ Fever or chills
   ☐ Rash
   ☐ Give way of your leg, falling down because of pain, locking of your joint
   ☐ Swelling or fluid on the joint or leg
   ☐ Numbness or tingling
   ☐ Weight loss
   ☐ Difficulty sleeping
   ☐ Depression
   ☐ Easy bruising

REVIEW OF SYSTEMS: Do you have any of these symptoms?

If yes, please check in the box below.

CONSTITUTIONAL
☐ Fever/Chills
☐ Weight Loss
☐ Weight Gain

CARDIOVASCULAR
☐ Chest Pain
☐ Irregular Heart Beat
☐ Poor Circulation

GU
☐ Bloody Urine
☐ Bowel or Bladder Problems

NEUROLOGICAL
☐ Weakness
☐ Frequent Headaches

BLOOD
☐ Bleeding Problems
☐ Previous Blood Transfusions

EYES
☐ Decreased Vision
☐ Cataracts

LUNGS
☐ Shortness of breath
☐ Wheezing
☐ Persistent Cough

MUSCULOSKELETAL
☐ Joint Swelling
☐ Muscles Aches
☐ Joint Pain

PSYCHIATRIC
☐ Depression/Anxiety/Panic
☐ Bipolar Disease

ALLERGIC
☐ Allergies to Foods
☐ Allergies to Latex

EAR, NOSE, AND THROAT
☐ Loss of Hearing
☐ Sinus Problems

GASTROINTESTINAL
☐ Stomach Pain
☐ Diarrhea
☐ Nausea / Vomiting
☐ Heartburn

SKIN
☐ Rash
☐ Dryness of Skin

ENDOCRINE
☐ Thyroid Problems
☐ Diabetes

☐ Are you pregnant?

PLEASE CONTINUE ON BACK PAGE.

ONGOING TREATMENTS:

Please list anyone who has treated you for this condition (physicians, chiropractors, physical therapist, and/or osteopaths) since YOUR LAST VISIT for your back/neck pain, along with the approximate dates.

Type of Treatment:	Response:	Approximate Dates:

Please check the box next to each treatment you have had for your pain in the past or currently.

TREATMENT	EFFECT OF TREATMENT			
	Currently Using	Helped	No Change	Increased
☐ Home exercise program	Yes	1	2	3
☐ Bed rest	Yes	1	2	3
☐ Hot packs/ice	Yes	1	2	3
☐ TENS unit for home use	Yes	1	2	3
☐ Back brace	Yes	1	2	3
☐ Physical therapy	Yes	1	2	3
☐ Massage	Yes	1	2	3
☐ Chiropractic treatment	Yes	1	2	3
☐ Osteopathic manipulation	Yes	1	2	3
☐ Acupuncture	Yes	1	2	3
☐ Radiofrequency Ablation (Rhizotomy)	Yes	1	2	3
☐ Epidural injections	Yes	1	2	3
☐ Facet injections	Yes	1	2	3
☐ Local (trigger point) injections	Yes	1	2	3
☐ Under care of pain specialists	Yes	1	2	3
☐ Other _____	Yes	1	2	3

What treatments have you done for pain?
Either mark below, or ☐ I haven't done anything for this pain.

MEDICATIONS	Was this effective?	Duration?
☐ Acetaminophen (Tylenol)		
☐ Ibuprofen (Advil)		
☐ Aleve, Naproxen		
☐ Celebrex, Mobic, Relafen		
☐ Glucosamine, Chondroitin		
☐ Neurontin (Gabapentin), Lyrica (Pregabalin)		
☐ Amitriptyline (Elavil), Nortriptyline (Pamelor)		
☐ Tramadol, Ultram, Ultracet		
☐ Cholesterol Lowering (Statin)		
☐ Narcotics Hydrocodone (Vicodin), Oxycodone (Percocet)		
☐ Flexeril (Cyclobenzaprine) Robaxin (Methocarbamol) Lioresal (Baclofen)		
☐ Other:_____		

PROGRESSION:

How is your current pain, compared to my last visit?

☐ Much improved ☐ Somewhat improved ☐ No change ☐ A little worse ☐ Much worse ☐ N/A

Work Status:

☐ Working regular duty ☐ Working light duty ☐ Not working Last day of work:_____

Any diagnostic tests (x-ray, MRI, EMG/NCV injections) since last visit?

Date	Type	Results

PLACE LABEL HERE, IF AVAILABLE
IF NOT, FILL IN FOLLOWING INFORMATION:

PATIENT NAME:_____

HISTORY NUMBER: _____

PATIENT DATE OF BIRTH:_____

LOCATION OF SERVICE: _____

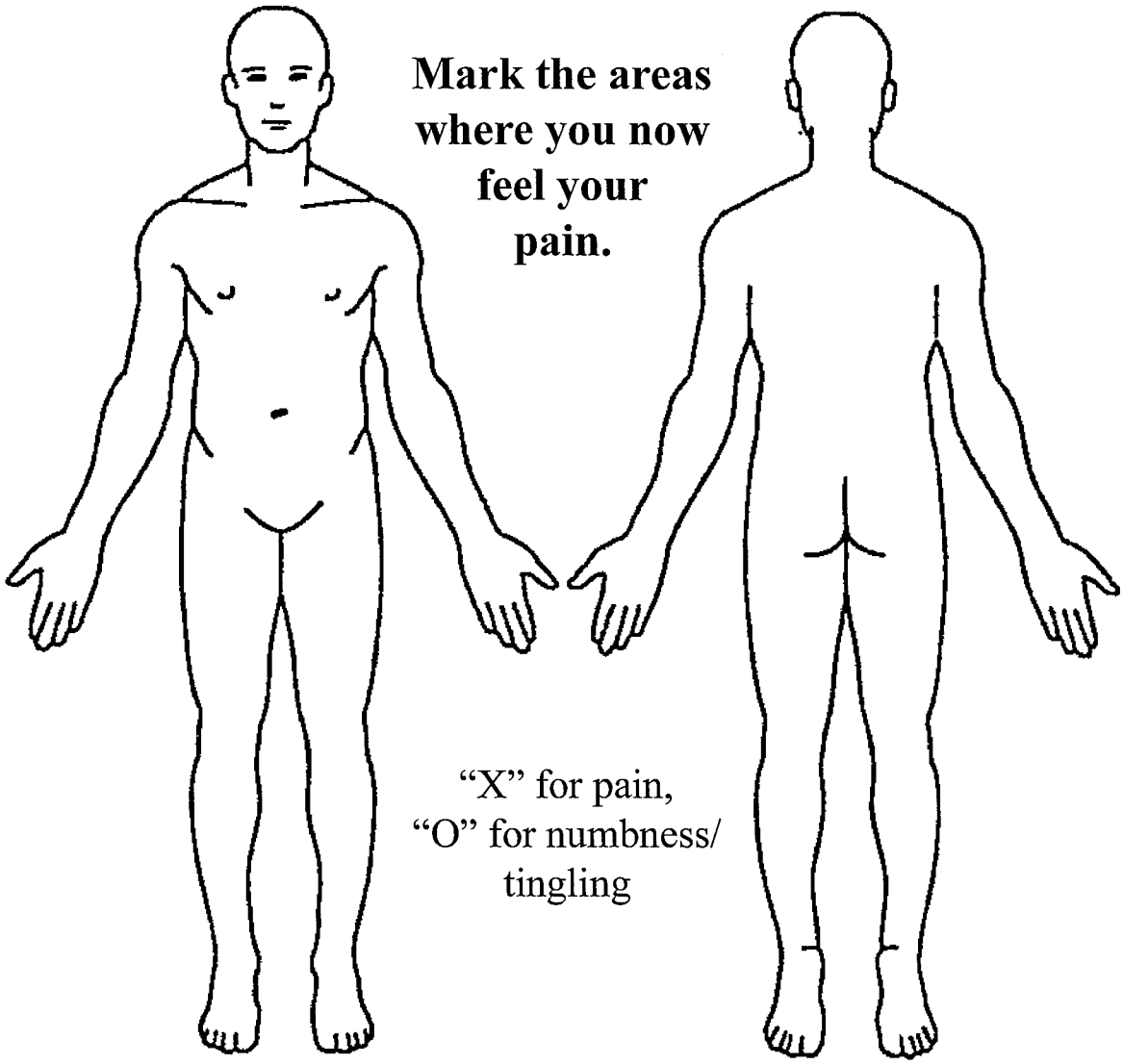
DATE OF SERVICE: _____

Provider Signature: _____

Date:_____

Confluence HEALTH

PAIN DIAGRAM



Out of 100%, how much of your pain/symptoms would you rate the affected body parts:

Neck: (If applicable)	+ _____%	Back: (If applicable)	+ _____%
Upper Extremity: (If applicable)	+ _____%	Lower Extremity: (If applicable)	+ _____%

***Total amounts must be equal to* 100%**

PLACE LABEL HERE, IF AVAILABLE
IF NOT, FILL IN FOLLOWING INFORMATION:

PATIENT NAME: _____

MRN: _____

PATIENT DATE OF BIRTH: _____

LOCATION OF SERVICE: _____

DATE OF SERVICE: _____