MPS FOLLOW UP VISIT DR FADAVI DR KING Date_____

Name_____ DOB_____

What is the reason for your visit today?_____

1.- Since my last visit I am: BETTER SAME WORSE

2.- What has been your average pain level since your last visit?

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)

3.- What has your level of function been since your last visit?

(Bed ridden) 0 1 2 3 4 5 6 7 8 9 10 (unrestricted activities)

3.- My pain is (circle all that apply): constant intermittent aching cramping dull sharp burning pressure-like throbbing tingling pins and needles numbness

4.- Since your last visit have you had any of the following? Physical therapy Home-PT TENS Traction Chiropractor MRI CT EMG Injections Surgery _____

5.- Please list your current pain medication:

Medication	**Strength**	**Frequency**

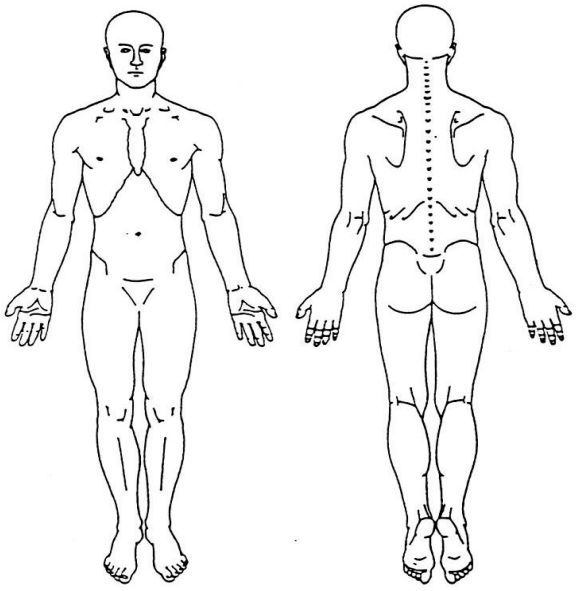
6.- Any side effects from the medication? Please list:_____

7.- Any new medical issues? Allergies? _____

8.- Have there been any changes in your social or family history? (employment, tobacco use, marital status, etc.)

_____

9.- Where is your pain? Circle below:



Circle if you have experienced one or more of the following:

- Fever – unexplained weight loss/gain - fatigue
- Chest pain- palpitations - chest tightness
- Shortness of breath- cough- wheezing
- Low back pain- neck pain- joint pain- muscle aches- muscle spasms,
- Rash- hair or nail changes -skin lesions
- Easy bruising- easy bleeding
- Headache- seizures- loss of balance, weakness - tingling – numbness
- Nervousness – anxiety - depression – Suicidal thoughts - hallucinations Insomnia
- Nausea – vomiting-bloating-diarrhea-constipation
- Frequent urination- burning urination -incontinence trouble voiding

10.- Are you considering harming yourself or harming others? YES NO

HT: WT: BP: TEMP: P: Patient's signature_____