ASSESSMENT FOLLOW-UP VISIT

(Patient form)

Date: ______________ **Patient Name:** ______________________________ **Date of Birth:** _________ **Age:** __

1. What is your preferred language for discussing your healthcare? English ___ Spanish ___ Other _______________
2. Are there any cultural, religious or emotional barriers with communication and learning? ____Yes _____No
   If "Yes", please comment ____
3. Do you have an Advanced Directive? ___Yes ___No If "No", would you like information on Advanced Directives? __Yes __No
4. Have you ever been admitted to a Hospital for overdose or pain? __Yes __No
5. Did the admission require a stay in the ICU? ___Yes ___No
6. Have you had additional x-rays, MRI's, etc. or seen any other specialist since your last visit? ____________________
7. Are you currently taking blood thinners? (i.e. Plavix, Coumadin) ___Yes ___No
8. Have you had any lab/blood work in the last three months? ___No If yes, please list ____________________________
9. Have you had a colonoscopy within the last year? ___Yes ____No
10. Where is the primary site of your pain? ____
11. What words best describe your pain (circle please): aching, throbbing, shooting, stabbing, sharp, tender, gnawing, burning, exhausting, tiring, penetrating, nagging, numb, miserable, unbearable, continuous
12. What time of day your pain is at its worse? (circle please): Morning, Afternoon, Evening, Nighttime
13. What makes your pain worse? Standing, Walking, Bending, Other: ____________________
14. What makes your pain better? Rest, Heat, Sitting, Standing, Other: ____________________
15. Do you have a history of falling or falls? ___No ___Yes [Please explain] _______________
16. Please list the medications, injections, physical therapy that you are receiving for pain and then describe the amount of pain relief and improvement in function that these medications, injections and/or physical therapy are giving you.
    For example: If you circle: 1-3: You are receiving excellent pain relief & improvement in function.
    If you circle: 4-6: You are receiving moderate pain relief & improvement in function.
    If you circle: 7-9: You are receiving mild pain relief & improvement in function.

    a) ______________________________ No Pain 0 1 2 3 4 5 6 7 8 9 10 No Relief
    Treatment or Medicine (include dose)
    b) ______________________________ No Pain 0 1 2 3 4 5 6 7 8 9 10 No Relief
    Treatment or Medicine (include dose)
    c) ______________________________ No Pain 0 1 2 3 4 5 6 7 8 9 10 No Relief
    Treatment or Medicine (include dose)
    d) ______________________________ No Pain 0 1 2 3 4 5 6 7 8 9 10 No Relief
    Treatment or Medicine (include dose)

    Please list any anti-depressants, anxiety medications or cold medicines you are taking: _____________
    ____
17. Do you smoke? No: __ Yes __ Cigarettes/Cigars/Smokeless Tobacco (How much daily? ___________)
18. Do you drink? No: __ Yes __ (How much: _________________________ daily/weekly/monthly)
19. Do you use recreational drugs? No: __ Yes ______ (Please list: ____________________________
20. WOMEN – Any possibility you could be pregnant? No ___ Yes____
21. What side effects or symptoms are you having now or have had during the past week? (Please Circle)
    a. Nausea None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    b. Vomiting None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    c. Constipation None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    d. Lack of Appetite None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    e. Tiredness None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    f. Itching None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    g. Nightmares None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    h. Sweating None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    i. Difficulty Thinking None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    j. Insomnia None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    k. Decreased Sexual Desire None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
    l. Decreased erection (Men) None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
22. What best describes your pain *now:* No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine
23. Any history of abuse or neglect? No___ Yes ___ [Please explain:] ______________________

Revival
PAIN MANAGEMENT

Patient Name: ______________________________ Date: ____________________

Review of Systems: Do you have now or have you had in the past 30 days?

	YES	NO
Fatigue		
Fever		
Chills		
Malaise		
Weight Change		
Lethargy		
Vision Changes		
Hearing Loss		
Neck Swelling		
Chest Pain		
Irregular Heart Beat		
Jaw Pain		
Arm Pain		
Shortness of Breath		
Coughing up Blood		
Diarrhea		
Constipation		
Stomach Pain		
Heartburn		
Black Tarry Stools		
Rectal Bleeding		
Urinary Frequency		
Bloody Urine		
Burning on Urination		
Skin Lesions/Ulcers		
Yellow Skin		
Blackouts/Fainting		
Headaches		
Dizziness		
Neck Pain		
Back Pain		
Unwanted Wt Change		
Hot/cold intolerance		
Increased Thirst		
Increased Urination		
Anxiety		
Depression		
Excessive Anger		
Suicidal Ideation		
Easy Bruising		

PAIN MANAGEMENT
110 Dutchman's Court
Elkin, NC 28621

SUICIDE RISK ASSESSMENT

Patient Name: ______________________________ Date: ____________________

	Ask Questions 1 and 2	YES	NO
1	Have you wished you were dead or wished you could go to sleep and not wake up within the last 30 days?	☐	☐
2	Have you actually had any thought of killing yourself within the last 30 days?	☐	☐

If Yes to 2, ask questions 3, 4, 5, and 6
If No to 2, go directly to question 6

		YES	NO
3	Have you been thinking about how you might do this	☐	☐
4	Have you had these thoughts and had some intention	☐	☐
5	Have you started to work out or worked out details how to kill yourself	☐	☐
6	Have you ever done anything, started to do anything, or prepared to do anything to end your life?	☐	☐
6a	If "YES" - Was it within the past 3 months	☐	☐

COMM QUESTIONAIRE					
Patient Name:	**Date:**				
DOB: ______________________	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
Please answer the questions using the following scale:	**0**	**1**	**2**	**3**	**4**
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?					
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)					
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)					
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
5. In the past 30 days, how often have you seriously thought about hurting yourself?					
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?					
7. In the past 30 days, how often have you been in an argument?					
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?					
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?					
10. In the past 30 days, how often have you been worried about how you're handling your medications?					
11. In the past 30 days, how often have others been worried about how you're handling your medications?					
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?					
13. In the past 30 days, how often have you gotten angry with people?					
14. In the past 30 days, how often have you had to take more of your medication than prescribed?					
15. In the past 30 days, how often have you borrowed pain medication from someone else?					
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?					
17. In the past 30 days, how often have you had to visit the Emergency Room?					
SUM:					

PATIENT DEMOGRAPHIC UPDATE

DATE: ______________________

PATIENT NAME: ____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

DATE OF BIRTH: ____________________________

MAILING ADDRESS: ____

CITY: ____________________ STATE: ______________ ZIP CODE: ______

TELEPHONE: HOME: _______________________________

WORK: _______________________________

CELL: _______________________________

EMAIL ADDRESS: ____

OR DECLINE EMAIL ADDRESS: ________