



**FOLLOWUP QUESTIONNAIRE**  
TO BE FILLED OUT BY THE PATIENT

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_

Name of the Doctor you are seeing today: \_\_\_\_\_ Referral physician \_\_\_\_\_

**Please answer the following sets of questions so that we can assess any progress you have made in your pain since your last office visit and/or procedure**

Where is your pain located: \_\_\_\_\_.

1. Since your last office visit, please rate your current pain status (*check the one that best applies*):.

- much better
- better
- unchanged
- worse

2. Which words best describe your pain since your last office visit? (*check all of the following that apply*):

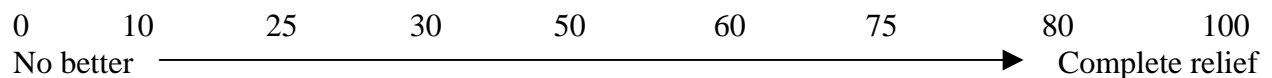
- shooting
- throbbing
- dull
- aching
- sharp
- electric shock
- burning
- tolerable

3. Which words best describe the timing of the pain since your last office visit? (*circle all that apply*):

- constant
- intermittent
- mostly in the morning
- mostly in the afternoon
- mostly in the evening
- very variable

4. At the last office visit, did you have a procedure?

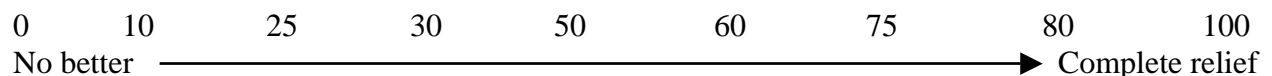
What percentage relief did you experience from this procedure?



5. Check the sentence that best describes the result of this procedure in relieving your pain.

- No relief
- The relief was temporary
- The relief was partial
- The relief was near complete
- No complications
- Temporary complications: (circle) increased pain. weakness. numbness. fever. Other: \_\_\_\_\_
- Persistent complications: (circle) increased pain. weakness. numbness. fever. Other: \_\_\_\_\_

6. If you were prescribed PAIN medications BY US for your pain, what percentage of relief have you received from them?



7. Check the term or terms that best describes your relief from the medications:

- No relief
- Partial relief
- Near complete relief
- No side effects
- Side effects: (circle) sleepy. nausea. headache. itching. constipation. Other: \_\_\_\_\_