INTEGRATIVE & REGENERATIVE PAIN MEDICINE • 7-E Oak Branch Dr • Greensboro, NC 27407 • 336-294-0910

FOLLOW-UP EVALUATION

Name: _____ Date: _____

1. What are your main areas of pain?_____
2. What was your pain level immediately after treatment?_____

3a. Please circle a number for the **LEAST** pain you experienced during the last week.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

3b. Please circle a number for the **MOST** pain you experienced during the last week.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

4. List anything that has improved since your last treatment session (e.g., sleep, activity level or abilities).

_____

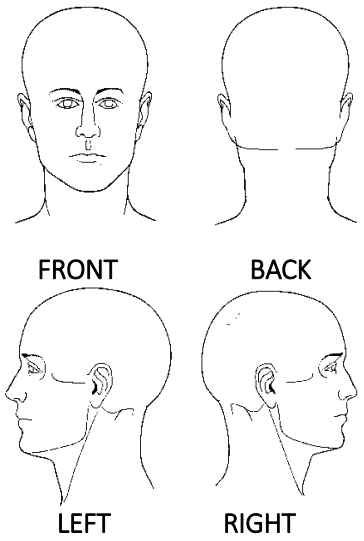
5. Any other observations (i.e., level of stress, effect of certain foods on your pain)_____

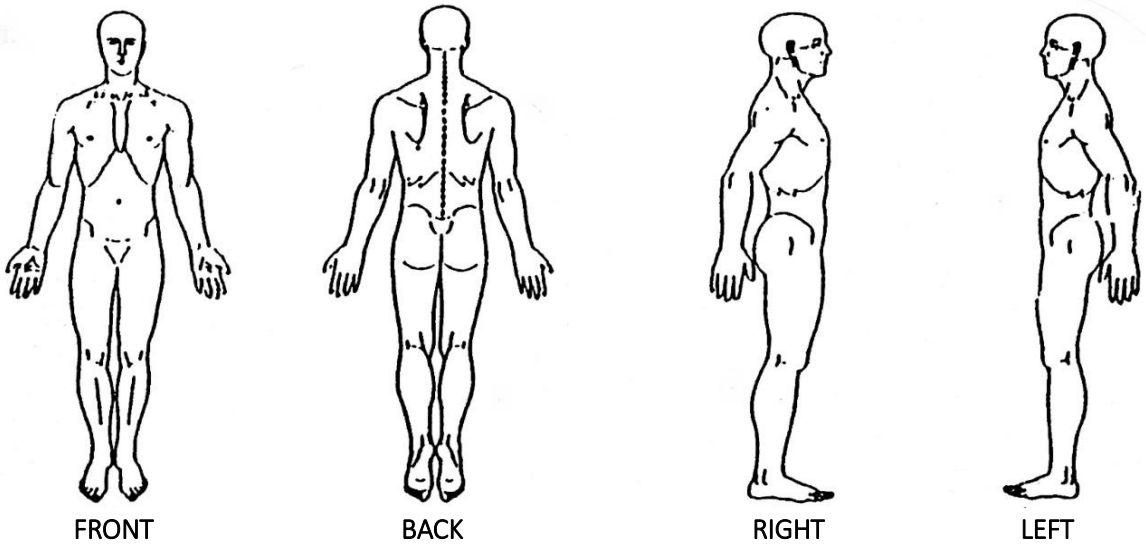
_____

6. List any medications you have stopped taking _____
or significantly reduced since your last visit _____
7. Are there any new medications that you started taking since your last session with the doctor?

Name of New Medication (dosage/amount)	How long have you been taking?	Frequency of use	Condition

8. Please shade in areas where you have pain and discomfort. Shade in more darkly those areas that have the greatest discomfort.





Please take a moment to address "Percentage Overall Improvement" for each condition since your first visit.

☐ None / Area	Left	Right	Pain	Stiffness	Numbness	Tingling	Burning	Resolved	Improving	Not Improving	Percentage (%) Overall Improvement
☐ Neck											
☐ Shoulder											
☐ Arm											
☐ Mid Back											
☐ Low Back											
☐ Hip											
☐ Leg											
☐ TMJ											
☐											
☐ Headache											

9. Is there anything in particular you feel you need to know or accomplish today? _____

_____