Tennessee Physical Medicine and Pain Management: T. Scott Baker, M.D.
Board Certified in Physical Medicine & Rehabilitation, Pain Medicine and Electrodiagnostic Medicine
PO Box 1165 • 1423 Baddour Pkwy • Lebanon, Tennessee 37087 • phone 615-257-0900 • fax 615-443-1444

Patient Questionnaire: **Follow Up Visit Date:** _____

Name: (first, middle, last) _____ **DOB:** _____

Chief Pain Complaint: (what **one** place hurts the most)? ☐ right ☐ left: _____

My pain radiates into☐right, ☐left, ☐arm, ☐leg. How far (be specific)_____

Other pain complaints: ☐neck ☐mid-back ☐low-back ☐buttock ☐shoulder ☐arm ☐hip ☐knee ☐_____

History of Present Pain: *(in the last month)*

My pain is: ☐dull ☐aching ☐cramping ☐sharp ☐stabbing ☐throbbing ☐burning ☐tingling ☐numb

Severity of my pain without medications:(**0=*none***) 0 1 2 3 4 5 6 7 8 9 10 (**10=*unbearable***)

Severity of my pain with medication: (**0 = *none***) 0 1 2 3 4 5 6 7 8 9 10 (**10=*unbearable***)

Pain interference with daily activities: (**0 = *none***) 0 1 2 3 4 5 6 7 8 9 10 (**10 =*bedridden***)

My Pain with the current treatment is ☐ unchanged ☐improved ☐worse ☐controlled ☐uncontrolled

Overall percentage of improvement: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

What is your current activity level with treatment (check all that apply/circle goals achieved)?

☐bathing ☐dressing ☐feed myself ☐grooming(wash/comb hair) ☐meal preparation ☐toileting ☐driving ☐shopping ☐care for pets ☐go to church ☐do outdoor chores (list) _____

☐do household chores (list)_____ ☐volunteer work ☐return to work ☐continue working ☐hunting /fishing ☐aerobic exercise ☐sports activities

Do you have any side effect from the medications? ☐constipation ☐nausea ☐over sedation ☐dizziness ☐itching ☐sweating ☐loss of appetite ☐confusion ☐diarrhea ☐heartburn ☐drunk feeling ☐_____

Treatments (√ if effective and X if ineffective)? ☐Tylenol ☐OTC NSAIDs ☐physical therapy ☐home exercise ☐TENS ☐lumbar brace ☐wrist brace ☐traction ☐muscle relaxer ☐Rx NASIDs ☐anti-depressant ☐anti-convulsant ☐opioids ☐office injection ☐fluoroscopically guided injections. If you had a fluoroscopically guided spinal injection what percentage relief did you receive? _____ and how long did it last?_____

Any diagnostic tests, surgery, hospitalization or ER visit since last evaluation? ☐none_____

Women only considering or on opioid treatment: are you pregnant? ☐yes ☐no.

Change in work status: ☐none _____

Change in mood? ☐none ☐normal/stable ☐unstable ☐depressed ☐irritable ☐sad/crying ☐anxious

Medications: Any new (or discontinued) medications since last visit? ☐none _____

Review of Systems *mark any of the following problems you are currently having:* ☐none ☐fevers ☐insomnia ☐ heartburn ☐ bowel or bladder incontinence ☐shortness of breath ☐leg swelling ☐rash

Patient Signature:_____ **Date**: _____