Coastal Spine & Pain

INTERVENTIONAL PAIN MANAGEMENT

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FOLLOW-UP PATIENT FORM

Please complete all fields at each follow-up visit. This helps us track your progress and adjust your treatment plan.

Patient Name:	
Date:	

PAIN ASSESSMENT

Today's Pain Score	Average Pain Score	Worst Pain Score
_____ / 10	_____ / 10	_____ / 10

What best describes your pain? *(Check all that apply)*

☐ Aching	☐ Burning	☐ Sharp	☐ Dull
☐ Pins/Needles	☐ Electrical	☐ Stabbing	☐ Numb
☐ Tingling	☐ Stinging	☐ Throbbing	☐ Cramping

What part(s) of the body is your WORST pain?	
Does your pain radiate into arms or legs? Explain:	
What TRIGGERS the pain (makes it worse)?	
What ALLEVIATES the pain (decreases it)?	

Pain Frequency: ☐ Constant ☐ Fluctuating but always present ☐ Comes and goes

Is your condition (PAIN and/or FUNCTION) since last visit:

☐ **IMPROVED** ☐ **UNCHANGED** ☐ **WORSE**

CURRENT PAIN MEDICATIONS — PLEASE DO NOT SKIP

Medication	Dose	Frequency	Date Started	Improved?	Side Effects

Any side effects with your medications? ☐ **NO** ☐ **YES** If YES, explain: _____

Pain improvement with current medications?	_____ %

Functional improvement with current medications?	_____ %
If you had a recent injection, overall improvement?	_____ %

FOR OFFICE USE ONLY

Patient Name:	**DOB:**	**MRN:**

Date of Last UDS:	Consistent / Inconsistent
PDMP Checked Today? ☐ Y / ☐ N	Consistent / Inconsistent
OA on File and Date (must be 1 per 12 months):	☐ YES / ☐ NO Date: ____/____/____
COMM on File? ☐ Y / ☐ N	Score:
ORT-OUD on File? ☐ Y / ☐ N	Score:
Oswestry on File? ☐ Y / ☐ N	Score:
PHQ-9 on File? ☐ Y / ☐ N	Score:
Most Recent Imaging on File?	Results:
Previous Plan:	Action:
Today's Plan:	

Orders / Imaging / Referral	**Medications**