Follow-up Visit Name: Date:

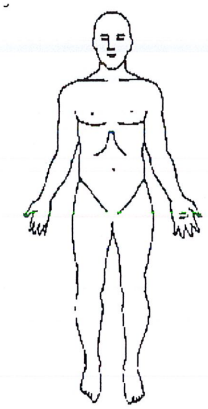
What is your main focus today? Medication refill Discuss Injections New Pain _____

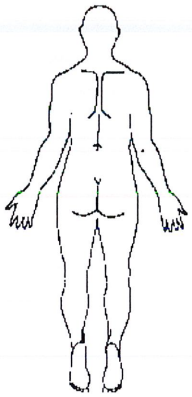
Any new medications, allergies, medical conditions, or doctors? Please list below:

_____

_____

On the diagram, shade the areas where you feel pain. Put an "X" on the area that hurts the most.





Current level of pain 1 -10 (10 is worst) _____

- Describe your level of pain over the last week:

  Circle one: Improved Worse No change Resolved

- Describe the frequency of your pain:

  Circle one: Intermittent Constant Occasional Rare

- How would you describe your pain? Circle all those that apply.

  Ache Burning Dull Numb Sharp Shooting Stabbing Throbbing

- What makes your pain worse? Circle all those that apply.

  Movement Sitting Standing Walking Stress Other: _____

- What relieves your pain? Circle all those that apply.

  Exercise Heat Ice Injections Medication Physical Therapy Rest Sitting Other: _____

Please rate your pain by circling the **ONE** number that best describes your pain at its **worst** in the **last week.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Please rate your pain by circling the **ONE** number that best describes your pain at its **least** in the **last week.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Please rate your pain by circling the **ONE** number that best describes your pain on **average.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Please list any **NEW** medications, doses, and any side effects you are experiencing since your last visit:

(Note: If all medication information is the same, write NO CHANGES)

Name	Dose	Times Taken Per Day	Prescribing MD	Side Effects

Circle the number that describes how during the **past week, pain has interfered with your:**

A. General Activity:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

B. Mood:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

C. Walking ability:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

D. Normal work:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

E. Relations with other people:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

F. Sleep:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

G. Enjoyment of life:

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely interferes

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____