

- Dr. Byers Dr. Su
 Dr. Sponzilli L.Elvin, NP



Spine Center
Follow-Up Form

| Last Name | First Name | MRN | Date |
|-----------|------------|-----|------|
| | | | |

| ✓ What best describes the purpose of your visit (all that apply) | |
|--|--|
| I had surgery and am here for follow-up | |
| I had imaging done (MRI, CT, etc) and am here to review the results | |
| Follow up for an existing problem. I have NOT had surgery or further imaging since my last visit | |
| New problem (different than what I have previously been seen for) | |

| | |
|---|--|
| In your own words, since your last visit, describe how your condition has changed or whether you have any new symptoms | |
|---|--|

| ✓ Treatment history <u>since last visit</u> | No | Yes | Details (If Yes) | ✓ Made my pain: | | |
|--|----|-----|--------------------------------------|-----------------|-----------|-------|
| | | | | Better | No Change | Worse |
| Medicine (ie Motrin, Aleve, Vicodin, Percocet) | | | Medication: | | | |
| Epidurals or Nerve Root injections | | | How many: Date of last injection: | | | |
| Physical Therapy | | | How long: | | | |

| Describe the quality and severity of your pain (circle) (0) Not at all, (1) Mild, (2) Moderate, (3) Severe | | | | | | |
|--|---|---|---|---|-------------------|---------|
| Throbbing | 0 | 1 | 2 | 3 | Gnawing | 0 1 2 3 |
| Shooting | 0 | 1 | 2 | 3 | Hot-Burning | 0 1 2 3 |
| Stabbing | 0 | 1 | 2 | 3 | Aching | 0 1 2 3 |
| Sharp | 0 | 1 | 2 | 3 | Heavy | 0 1 2 3 |
| Cramping | 0 | 1 | 2 | 3 | Tender | 0 1 2 3 |
| | | | | | Splitting | 0 1 2 3 |
| | | | | | Tiring/Exhausting | 0 1 2 3 |
| | | | | | Sickening | 0 1 2 3 |
| | | | | | Fearful | 0 1 2 3 |
| | | | | | Punishing-Cruel | 0 1 2 3 |

