PAIN SCALE

(PLEASE USE SCALE FOR FOLLOWING QUESTIONS)

	SYMPTOMS
1 (ONE)	Pain free
2 (TWO)	Very minor annoyance—I have occasional minor twinges
3 (THREE)	Annoying enough to be distracting
4 (FOUR)	Can be ignored if busy, but still distracting
5 (FIVE)	Can't be ignored for more than 30 minutes
6 (SIX)	Can't be ignored for any length of time but can still work and do social activities
7 (SEVEN)	Makes it difficult to concentrate, interferes with sleep, can function with effort
8 (EIGHT)	Physical activity severely limited, can read and speak with effort, experience nausea and dizziness
9 (NINE)	Unable to speak, crying out or moaning uncontrollably
10 (TEN)	Either unconcious or it makes you want to pass out

PLEASE COMPLETE ALL FORMS FOR YOUR APPOINTMENT

Michigan Orthopedic Spine Surgeons

Follow-Up Patient Evaluation

Patient's Name _____ Date of Birth _____ Today's Date _____

Reason for Visit:

- Post-op: Date of surgery:_____
  - Cervical fusion
  - Lumbar fusion
  - Lumbar lami/disc
- Test result:
  - MRI
  - CT Scan
  - Bone Scan
  - CT/Myelogram
- Post procedure
- Follow up
- Surgical consult
  - Date held:_____
- Incision check Y / N
- Auto related Y / N Date_____
- Work related Y / N Date_____

Height_____ Weight _____ Blood Pressure _____

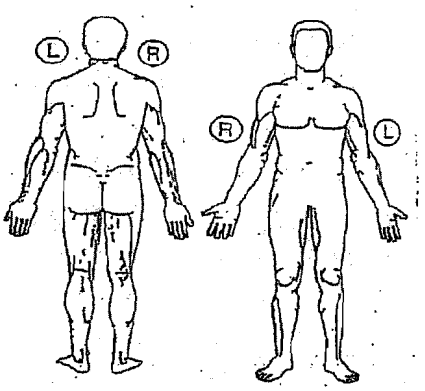
Since last visit or surgery your quality of life is: Better Worse Same

Where is your pain:

- Cervical
- Thoracic
- Lumbar
- Extremity: _____

Use the picture to shade the location of:

- AAAA – Aching
- SSSS – Stabbing
- NNNN - Numbness
- PPPP – Pins and Needles
- TTTT - Tingling



In the boxes below please circle all that apply to your complaints/condition.

Neck/Back Quality of Pain	Pain Radiating	Associated/Other Symptoms
• Achy • Burning • Cramping • Deep • Dull • Heavy • Sharp • Shooting • Throbbing • Tight	• Back of head • Front of head • Side of head R/L • Right arm • Left arm • Right/Left hand • Right leg • Left leg • Right/Left foot • Buttocks	• Bowel/bladder changes • Difficulty swallowing • Numbness • Spasms • Stiffness • Tingling • Weakness • Other _____

Symptoms Improved With	Symptoms Worse With	Treatment you have tried

PLEASE COMPLETE THE OTHER SIDE.

• Heat • Changing body position • Cold • Exercising • Lying down • Resting • Sleeping • Standing • Stopping activity • Walking • Other _____	• Bending • Changing body position • Cold • Exercising • Heat • Lifting • Lying down • Pushing/pulling • Resting • Sitting • Standing • Stopping activity • Walking • Other _____	• On restrictions • Acupuncture • Anti-inflammatory medications • Chiropractic • Epidural Steroid injections • Herbal medications • Hot packs • Massage • Medrol dose pack • Muscle relaxants • Narcotics • Pain management • Physical therapy • TENS unit • Other _____

Rank pain level on a scale of 0-10.

Neck/Back with Medication:	0	1	2	3	4	5	6	7	8	9	10
Neck/Back without Medication:	0	1	2	3	4	5	6	7	8	9	10
Arm/Leg with Medication:	0	1	2	3	4	5	6	7	8	9	10
Arm/Leg without Medication:	0	1	2	3	4	5	6	7	8	9	10

Medications: Please list all medications you are currently taking.

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PLEASE COMPLETE THE OTHER SIDE.

Extended Care Facility:
Are you currently residing in an Extended Care Facility? Yes or No

If yes name of Facility: _____

Physician prescribing pain medication _____

Or pain management physician_____

Allergies: Please list any drug allergies Latex allergy? Yes No

_____

_____

Social History

- Occupation _____
- Disabled: Date _____ **Permanently** or **Temporarily**

Tobacco Use

- I have never smoked.
- I used to smoke, but I quit on _____.
- I currently smoke _____ packs per day.
- I chew tobacco.

Physician's use only:

Brace: Type_____ Dispensed_____ Script given_____