CLEARWAY℠
PAIN SOLUTIONS INSTITUTE

FOLLOW-UP WORKSHEET

Patient Name ______________________ DOB __________ Age ______

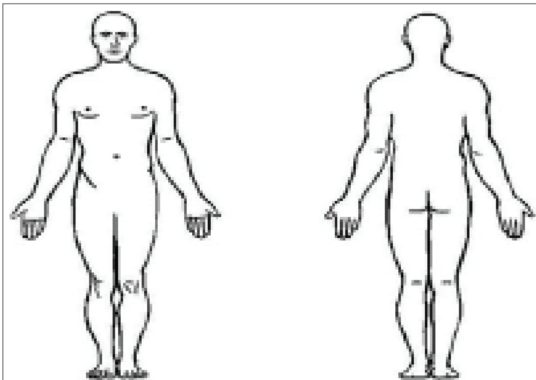
Primary Care Physician ______________________ Today's Date __________

IF YOU HAVE BEEN IN A MOTOR VEHICLE ACCIDENT PLEASE ALERT FRONT DESK FOR POSSIBLE ADDITIONAL INFORMATION REQUIRED

Patient History

1. What is your main pain complaint? ______________________
2. Is your pain related to a work accident or motor vehicle accident? ❑ No ❑ Yes, when? __________
3. **Have you had a new injury since last office visit? ❑ Yes ❑ No If yes, please explain:** __________
4. How would you describe your pain? ❑ Sharp ❑ Achy ❑ Burning ❑ Shooting ❑ Constant ❑ Intermittent
5. What increases your pain? ❑ Walking ❑ Bending ❑ Standing ❑ Sitting ❑ Weather ❑ Laying Down ❑ ____
6. What decreases your pain? ❑ Walking ❑ Bending ❑ Meds ❑ Sitting ❑ Laying Down ❑ __________
7. Injection on last visit? ❑ Yes ❑ No If yes, % of improvement __________
8. What you are currently doing? ❑ Stretching ❑ Chiropractic Care ❑ Physical Therapy ❑ Massage ❑ ______
9. **New X-Rays/MRI since last visit? ❑ Yes ❑ No If yes, where?** __________
10. Do you smoke? ❑ Yes ❑ No If yes, how many packs per day? ______ How many years? ______
11. Do you drink? ❑ Yes ❑ No If yes, how many drinks per day? __________
12. Are you currently working? ❑ Yes ❑ No If yes, where? __________ If no, why? __________
13. Are you currently on disability? ❑ Yes ❑ No If yes, what are you on disability for? __________
14. How would you rate your pain (Scale of 0-10: 0 = no pain, 6 = hard to ignore, 10 = worst pain possible):
    Rate your pain now: ______ Rate your pain at its best: ______ Rate your pain at its worst: ______
15. Pain relief with medications? ❑ Yes ❑ No Improved function with meds? ❑ Yes ❑ No
    Side Effects? ❑ Yes ❑ No Sedation? ❑ Yes ❑ No Insomnia? ❑ Yes ❑ No Constipation? ❑ Yes ❑ No
16. **What medications do you receive from our Pain Management Physicians? ❑ None ❑ I need refills without changes ❑ I need changes:** __________
17. What medications do you receive from <u>**other Physicians**</u>? ❑ None ❑ Blood Thinners ❑ BP Meds
    ❑ Diabetic Meds ❑ Anxiety Meds ❑ Sleeping Meds ❑ Pain Meds ❑ Other __________
18. **Have you had PT or Chiropractic care in the last 12 months?** ❑ Yes ❑ No If yes, what/when ______
19. **Have you had a back brace or tens unit in the last 2 years?** ❑ Yes ❑ No If yes, what/when ______
20. **Have you had imaging studies in the last 2 years?** ❑ Yes ❑ No If yes, when/where ______
21. **Review of systems:** Have you had any new medical diagnosis or symptoms since your last office visit?
    ❑ Yes ❑ No I have had the following: __________

Mark Below Where You Hurt



OFFICE STAFF USE ONLY

TRIAGE MA REVIEW ■ UDT schedule reviewed (red flag if needed)
■ Imaging / PT / Chiro / Tens (green flag if needed)
■ Reviewed Medications in EHR with patient?
■ Verified Pharmacy? ❑ Rx Printed
■ Documented blood thinners (flowsheet)?
■ Verified Allergies?
■ PATIENT INSTRUCTIONS ❑ Diet ❑ Exercise
■ CARE PLAN ❑ Consent ❑ HEP ❑ Med Assessment
PROVIDER: ❑ Med Discussion ❑ Injection Therapy ❑ Procedure Indications
❑ Urine Med Manag ❑ Rehab/Wellness ❑ Brace
OTHER ❑ TPI ❑ Toradol ❑ Decadron ❑ ______________________

DIAGNOSIS
❑ Same ❑ New ❑ Old
❑ Declined ❑ Improved
❑ 99213 ❑ 99214 ❑ 25
❑ ____________