UT Physicians

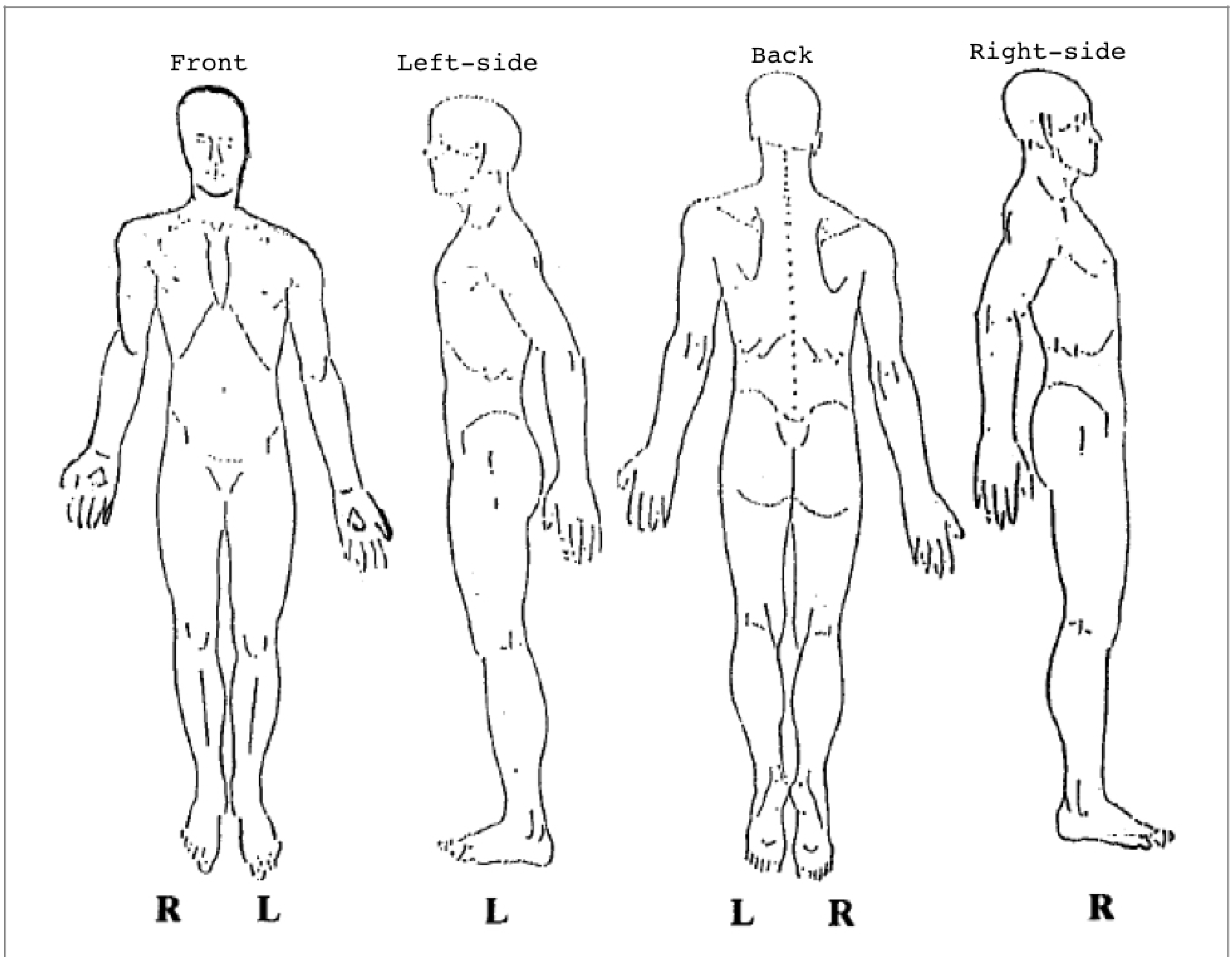
PM&R Clinic Follow Up Questionnaire

Patient Name:
MRN:
Date of Birth:

Pain Location
Only for the pain in the body region that you are being seen for today:

Choose the symbol(s) shown below that best describes the pain you are having (e.g. Δ Δ Δ means an aching type of pain), and draw the location of your pain on the body map

Aching: Δ Δ Δ | Numbness = = = | Pins & Needles 000 | Burning XXX | Stabbing or Sharp /// | Other . . .



Pain Intensity

Please rate your **pain intensity, for your primary pain,** by marking the number that best describes your pain. 0 = no pain, 10 = most severe pain

	0	1	2	3	4	5	6	7	8	9	10
Worst pain this past week											
Least pain this past week											
Average pain this past week											
Current pain severity											

Pain Relief

Since your last visit, how much relief have pain treatments and/or medications provided? Please mark the one percentage that most shows how much **relief** (reduction in pain severity and/or frequency) you have received. 0% means no relief at all, 100% means complete relief.

	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
% of pain relief from medications and/or other pain treatments											

Is there anything else you'd like to discuss with your physician today?

For clinic use only

Intake form reviewed

Signature of reviewer

Date or review