

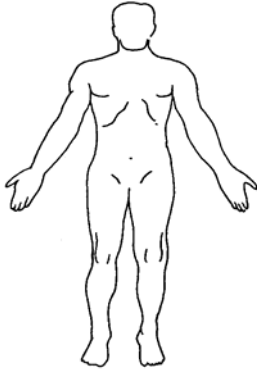
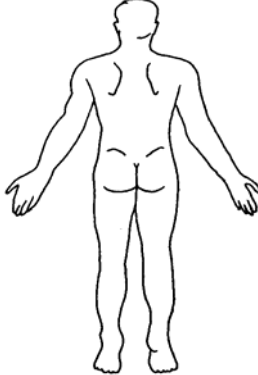
FOLLOWUP QUESTIONNAIRE

1. Name _____ Date _____

2. Age _____ last _____ Sex: M F first _____ 3. Primary Doctor _____

4. Attorney _____ 5. Adjuster _____ 6. Referring Doctor _____

6. Mark the location(s) of your pain with an "X." and show where it goes with an arrow. Circle the words which best describe you pain

sharp	 <p style="text-align: center;">R <i>Front</i> L</p>	shooting	 <p style="text-align: center;">L <i>Back</i> R</p>	burning
throbbing		electric-like		skin sensitivity to light touch, cold
cutting		pins and needles		abnormal swelling, hair/nail growth
dull, aching		weakness		abnormal sweating
pressure		numbness		abnormal skin color changes
muscle pain				abnormal skin temperature
cramping				limited movement

7. Pain Intensity. Circle your **current** pain intensity with "0" representing no pain and "10" the most severe pain imaginable

0 1 2 3 4 5 6 7 8 9 10

Is there any chance you might be pregnant? Yes No N/a

8. Prior injections or procedures

DATE	NAME OF PROCEDURE	HOW MUCH PAIN RELIEF ?	FOR HOW LONG?	SIDE EFFECTS
1.		%		
2.		%		
3.		%		

9. List your current medications and dosage

Medication	Dosage	Number per day	Benefits/side effects	Refill needed

10. Allergies to medications (including antibiotics, local anesthetics, x-ray contrast dye, iodine, latex materials):

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Please do not write below

IMPRESSION

1.	4.
2.	5.

Risk, benefits, alternatives of procedure explained to patient Yes No The patient understands and consents Yes No ASA I II III IV

PROCEDURE

1.

RECOMENDATIONS

1.	6.
2.	7.

_____/Val Tarasenko, M.D./