New Day Pain & Wellness
Interventional Pain Specialist

Patient's Name_____ **Date**_____

Follow- up Questionnaire

1. Is your pain: _____ Better _____ Worse _____ Unchanged
2. Any new issues: _____
3. What is your current level of pain (Scale 1-10)? _____
4. Have you had an injection since last visit? ____ Yes ____ No
    a. What's the percent of relief from injection if any? _____%
5. Do you take any pain medications? ____ Yes ____ No
    a. Any side effects of prescribed medications? _____ Yes _____ No
    b. Are medications helping your pain? ____ All the time ___Sometimes _____Rarely
    c. What's the percent of relief from medication given if any? _____%
    d. Current functional level with medication? ____Better ___ Much Improved ___Very Poor
6. Quality of sleep: _____ Good _____ Fair _____ Poor
7. Describe your mood: _____ Good _____ Fair _____ Poor _____ Depressed

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Official use only:

Medication Reconciliation:

Pain:	**B/P:**	**HR:**	**RR:**	**Temp:**	**O2 Sat:**