

## Follow-up Evaluation Questionnaire

Date: \_\_\_\_\_ Name: \_\_\_\_\_

The questions below are to be answered based on your experience while taking pain medications (if applicable).

1. Since your last appointment, how has your pain changed?

- Pain has increased  Pain has decreased slightly  Pain has decreased considerably  
 Pain has stayed the same  Pain has decreased moderately  Pain has gone away completely

2. If an injection or manipulation was performed at or since your last office visit, did it provide relief in the treated area? YES NO

3. Which statement best describes your pain now? (Check one)

- Always present – always the same intensity  Often present – have pain-free periods lasting over 6 hours  
 Always present – intensity varies  Occasionally present – once to several times a day up to 1 hour  
 Often present – have short periods without pain  Occasionally present – brief periods for a few seconds to minutes  
 Often present – have pain-free periods of 1-6 hours  Rarely present

4. Since your last visit, on a scale of 0 to 10 (see following page for description of the numbers):

What is your **minimum** level of pain? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

What is your **average** level of pain? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

What is your **maximum** level of pain? (Circle #) 0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to

- Fall asleep  Both  
 Stay asleep  Neither

Does this occur: Every night Most nights Some nights

6. On most mornings do you feel rested? Yes No

7. If you take medication for pain, how do you take it?  As needed for pain  Regularly by the clock

8. Since treatment began, has your need for pain medication:

- Increased slightly  Decreased slightly  Stayed the same  
 Increased moderately  Decreased moderately  
 Increased greatly  Decreased greatly

9. How much relief is your current pain medication regimen providing?

- Slight amount  About 50%  Almost complete  
 About 25%  About 75%

10. Do you feel the pain medication improves your ability to function better during the day?  Yes  No

11. What side effects, if any, are you experiencing from the medication? \_\_\_\_\_

12. Since your last visit, have you...

- Had any alcohol to drink  Obtained pain medication from another physician  
 Taken more medication than prescribed without authorization  Borrowed or shared any pain medications  
 None of the above

13. Do you feel we have helped you with your pain problem?

- Yes, a great deal  Yes, slightly  
 Yes, moderately  No, not at all

14. Since you were last treated for pain in this clinic, how many days of work have you missed because of pain? \_\_\_\_\_ days.

15. Since you were last treated for pain in this clinic, how many times have you visited the hospital for pain? \_\_\_\_\_ times.

16. Since you were last treated for pain in this clinic, approximately how many physician visits have you had for pain? \_\_\_\_\_

17. Other than a prescription refill, what other issues would you like to discuss today?

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*Thank you for helping us evaluate your progress.*

0 – Pain free

1 – Very minor annoyance, occasional minor twinges. No medication needed

2 – Minor annoyance, occasional strong twinges. No medication needed

3 – Annoying enough to be distracting. Occasional mild pain medications take care of it (i.e. Tylenol, aspirin, ibuprofen)

4 – Can be ignored if you are really involved in work, but still distracting. Mild pain meds provide 3-4 hours of complete relief

5 – Cannot be ignored for more than 30 minutes. Mild pain medications provide 3-4 hours of moderate relief

6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities. Stronger pain medications reduce pain for 3-4 hours (i.e. Codeine, narcotics)

7 – Difficult to concentrate and interferes with sleep, but you can still function with effort. Stronger pain medications are only partially effective

8 – Physical activity is severely limited. It takes effort to read and converse. Nausea and dizziness set in as factors of pain

9 – Unable to speak, crying out or moaning uncontrollably – near delirium

10 – Unconscious, pain causes you to pass out