SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

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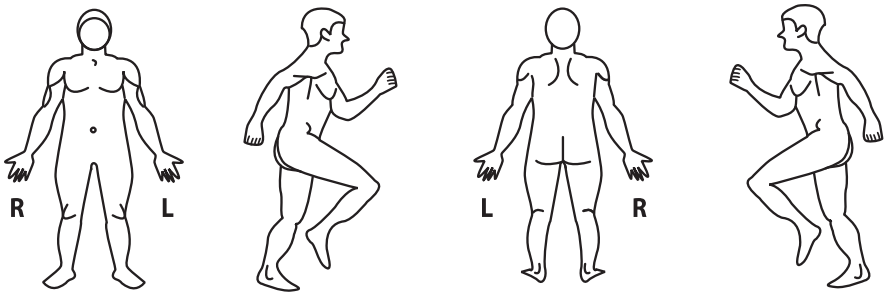
FOLLOW-UP ASSESSMENT

Name _____ Doctor _____ Date _____

Date of Birth _____ Primary Care Physician _____ MR# _____

1. Please shade the area(s) of your pain that we are seeing you for today.



2. Status of pain since your last visit here: ❑ Better ❑ Worse ❑ Same

3. Please indicate the level of your pain.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

4. Please check the words that best describe the pain for which we are seing you.

❑ Aching ❑ Bruising ❑ Dull ❑ Numbing ❑ Sharp
❑ Cramping ❑ Radiating ❑ Stabbing ❑ Stinging ❑ Tingling

5. Duration of Symptoms: ❑ Constant ❑ Comes and Goes ❑ Infrequent

6. Have you recently had any treatments for the condition for which we are seeing you?

❑ Injections ❑ Physical Therapy ❑ Chiropractic Care ❑ Medications ❑ Massage

7. Did you have any pain relief from the treatment(s)? ❑ Yes ❑ No
If yes, how much improvement did you receive?
❑ 0% ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

8. Are you working? ❑ Full Duty ❑ Light Duty ❑ Not Working

9. Since your last visit here, have you seen your Primary Care Physician (PCP)? If yes, please explain:

_____

_____

10. Has your PCP or any other medical specialist made any changes to your medication? If so, what is the name of the medicine?

_____

_____

11. Since your last visit here, have you been hospitalized or had surgery? If yes, please explain:

_____

_____

For Office Use Only:

GSSC-44, Rev. (04-14)

12. Please check the activities that increase, decrease or do not change the pain for which we are treating you:

ACTIVITY	INCREASE PAIN	DECREASE PAIN	NO CHANGE
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Lying Down	❑	❑	❑
Changing Positions	❑	❑	❑
Leaning Forward	❑	❑	❑

13. Mark the following signs and/or symptoms you experience:

Constitutional:
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Weakness
- ❑ Weight Gain
- ❑ Weight Loss

HEENT:
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Difficulty or Pain with Swallowing
- ❑ Ear Drainage
- ❑ Facial Pain
- ❑ Headache
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Nasal Congestion
- ❑ Ringing in Ears
- ❑ Vertigo
- ❑ Vision Loss

Respiratory:
- ❑ Chest Pain (Respiratory)
- ❑ Cough
- ❑ Recent Infections
- ❑ Known TB Exposure
- ❑ Wheezing
- ❑ Difficulty or Pain with Breathing

Cardiovascular:
- ❑ Chest Pain
- ❑ Heart Murmur
- ❑ Leg Swelling
- ❑ Syncope
- ❑ Irregular Heartbeat/ Palpitations

Gastrointestional:
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Black Tarry Stools
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Jaundice
- ❑ Loss of Appetite
- ❑ Nausea
- ❑ Vomiting

Genitourinary:
- ❑ Pain with Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Urge Incontinence
- ❑ Urinary Incontinence

Metabolic/Endocrine:
- ❑ Cold Intolerant
- ❑ Hair Loss
- ❑ Heat Intolerant

Neurological:
- ❑ Difficulty Walking
- ❑ Dizziness
- ❑ Poor Coordination
- ❑ Memory Loss
- ❑ Muscle Weakness
- ❑ Seizures
- ❑ Tremors

Psychiatric:
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia

Integumentary:
- ❑ Contact Allergy
- ❑ Itchy Skin
- ❑ Rash
- ❑ Skin Infections
- ❑ Skin Lesion

Hematologic:
- ❑ Bleeding
- ❑ Bruising

Immunological:
- ❑ Asthma
- ❑ Bee Sting Allergies
- ❑ Environmental Allergies
- ❑ Food Allergies
- ❑ Seasonal Allergies
- ❑ Latex Allergy

❑ None of these apply to me

Signature: _____ Date: _____