JARED MYERS, D.O.
VIRGINIA MABASA, PA-C

RISSER ORTHOPAEDIC GROUP

PMR & INTERVENTIONAL PAIN MANAGEMENT FOLLOW-UP

Name: _____

Have any of the following changed since our last visit? (Circle one)

Medical condition/hospitalization	YES	NO
New diagnostic studies	YES	NO
Employment status/restrictions	YES	NO

Are you currently receiving or performing any of the following treatments? (Circle one)

TENS/Interferential Current	YES	NO	
Acupuncture	YES	NO	
Massage therapy	YES	NO	
Physical therapy	YES	NO	Name: _____
Chiropractic care	YES	NO	Name: _____
Independent exercises	YES	NO	

If you recently have been participating in therapy/chiropractic/acupuncture/massage therapy, how much relief would you say you received? _____% (0-100%)

If you recently had a procedure, how much relief did you receive compared to pre-injection? _____% (0-100%)

Please answer the following about your pain:

Which position **INCREASES** your pain? (please circle all that apply) ANY ACTIVITY

BENDING FORWARD	BENDING BACKWARD	REACHING	LYING ON BACK	LYING ON STOMACH
SITTING	WEIGHTBEARING	STANDING	WALKING	CHANGING POSITIONS
ROTATION	COUGHING	SNEEZING	WORKING	MOVING AROUND
LYING ON LEFT SIDE	LYING ON RIGHT SIDE	PHYSICAL THERAPY		RECENT INJECTION

Which position **REDUCES** your pain? (please circle all that apply) HEAT ICE ANY ACTIVITY

BENDING FORWARD	BENDING BACKWARD	REACHING	LYING ON BACK	LYING ON STOMACH
SITTING	WEIGHTBEARING	STANDING	WALKING	CHANGING POSITIONS
ROTATION	COUGHING	SNEEZING	WORKING	MOVING AROUND
LYING ON LEFT SIDE	LYING ON RIGHT SIDE	PHYSICAL THERAPY		RECENT INJECTION

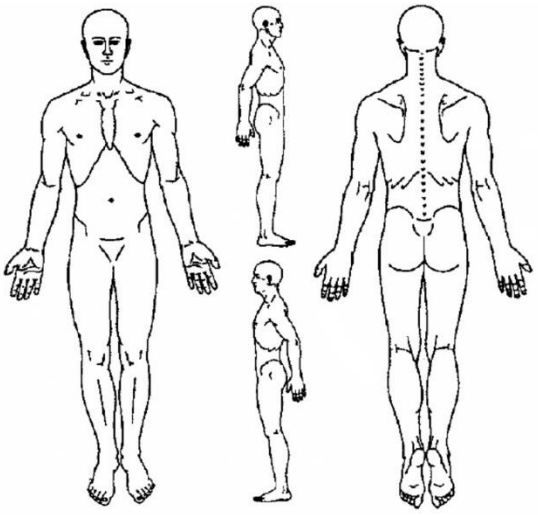
Please list any additions or discontinuations of medications since your last visit: _____

_____

Please circle your current pain level 0 1 2 3 4 5 6 7 8 9 10

Please circle your highest pain level over the past week 0 1 2 3 4 5 6 7 8 9 10

Please circle you lowest pain level over the past week 0 1 2 3 4 5 6 7 8 9 10



Would you **describe the pain** as: please circle all that apply:

BURNING SHARP ACHING THROBBING SHOOTING

OTHER: (describe) _____

_____

_____

_____

_____

Please mark the figure with the location of your symptoms as a result of this injury or accident:

Pain = X **Numbness/Tingling = #**

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