

**DR. FOWBLE'S FOLLOW-UP QUESTIONNAIRE**

**DATE:** \_\_\_\_\_ **NAME:** \_\_\_\_\_ **CHART#** \_\_\_\_\_

1. What problem are seeing you for today? \_\_\_\_\_
2. When did we see you last for this problem? \_\_\_\_\_
3. Since your last visit? \_\_\_\_\_ Better? \_\_\_\_\_ Worse? \_\_\_\_\_ Same?
4. On a scal of 0-10 (based on description) what is your current pain level? \_\_\_\_\_

\_\_\_\_\_(0-2) HAVE LITTLE OR NO PAIN

\_\_\_\_\_(3-5) MILD TO MODERATE PAIN (able to perform daily activities without limitations)

\_\_\_\_\_(6-8) MODERATE TO SEVERE PAIN (able to perform daily activities but with limitations)

\_\_\_\_\_(9-10) SEVERE/DEBILITATING PAIN (not able to perform daily activities bedridden due to pain)

Describe the quality of pain ( ) Not Applicable

( ) SHARP	( ) THROBBING	( ) DULL	( ) ACHING	( ) STABBING	( ) BURNING
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5. Is the pain: \_\_\_\_\_ CONSTANT \_\_\_\_\_ INTERMITTENT
6. What medications are you still taking for this condition?

7. Use lines below to show what treatment was done since your last visit:

TREATMENT	DID IT HELP		
____ Anti-inflammatories	____ Yes	____ No	____ N/A
____ Narcotics	____ Yes	____ No	____ N/A
____ Brace/Cast	____ Yes	____ No	____ N/A
____ Physical/Occupational Therapy	____ Yes	____ No	____ N/A
____ Home exercise program	____ Yes	____ No	____ N/A
____ Injection at Last Visit: Short Term	____ Yes	____ No	____ N/A
____ Injection at Last Visit: Long Term	____ Yes	____ No	____ N/A

