Integrated Pain Specialists of Southern California, Inc.
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Returning Patient Questionnaire

Patient's Name: ______________________ Today's Date: ____________

Patient's DOB: ______________ Treating Doctor: ________________

Since the last time you were here, have you: **Please complete Items 1-7**

1.) Had any changes in your pain? Yes No (circle one)
If so, please describe: ____________________________________

____

2.) Had any pain relief? Place an "X" on the scale below to indicate pain relief
No relief Complete relief

____

0% 25% 50% 75% 100%

3.) Where would you rate your current pain? Place an "X" on the scale below
No pain Worst possible pain

____

0 1 2 3 4 5 6 7 8 9 10

4.) Had any other evaluations since we've last seen you? Yes No
If so, please describe: ____________________________________

____

5.) Had any changes in the medications you are taking? Yes No
If so, please describe: ____________________________________

____

6.) Circle if you are presently taking any of the following medications that may affect your bloods ability to clot:

Coumadin, Aspirin, Heparin, Lovenox, Motrin, Ibuprofen, Excedrin, Celebrex, Plavix

7.) Had any changes in: (circle all that apply)

Levels of physical activity Work Sleep Appetite Mood Social life Leisure time

If so, please describe: ____________________________________

____

Ht: ________ Wt: ________ BP: ________ P: ________ T: ________

Medication given: ____

Nurse/Physician Comments: __________________________________

____

Date of Last Visit: __________ Procedure done: ________________

Today's Procedure: ____

Room #: __________