PHONE/FAX 702.779.3994
SUSPINEANDSPORTS.COM English / Espanol / Chinese

2585 Montessouri Street, Suite 100
Las Vegas, NV 89117

2995 South Jones Blvd.
Las Vegas, NV 89146
(Personal Injury Only)

RETURNING PATIENT FORM

FOLLOW-UP VISIT FORM

Name: ______________________________ **Gender:** [ ] Male [ ] Female

DOB: ____________________ **Pharmacy (If changed):** ____________________

Address: (If changed): ______________________________

Insurance (If changed): ____________________ *Please give your new insurance card to the front desk.*

MAIN REASON OF THIS VISIT

[ ] Medication Refill [ ] Medication Change [ ] Post-injection Follow-up [ ]MRI Results Follow-up
[ ] Other Results Follow-up

POST-INJECTION

What percentage of pain relief did you get? ____________________

Were there any problems? [ ] No [ ] Yes

MEDICATION REGIMEN

Are you TAKING any medication for blood-thinner? [ ] No [ ] Yes

List ALL medications you are TAKING.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

[ ] I authorize Humanity Health Center to access my electronic medication history and formulary information.

MEDICATION SIDE-EFFECTS

[ ] I do NOT have any adverse side effects from current medications.

[ ] I am stable on my current medication regimen.

[ ] My medications help to improve my functioning and quality of life.

Mark ALL side-effects you are experiencing: [ ] Confusion [ ] Constipation—less than 3 times per week
[ ] Dizziness [ ] Drowsiness [ ] Dry Mouth [ ] Nausea [ ] Vomiting [ ] Weight Gain

CHANGES SINCE LAST VISIT

Have you developed any new pain since last visit? [ ] No [ ] Yes

Has your pain changed since last visit? [ ] Decreased [ ] Increased [ ] Stayed the same

Have you developed any new symptoms since last visit?
[ ] Balance problem [ ] Bladder incontinence [ ] Bowel Incontinence [ ] Chills
[ ] Difficulty Walking [ ] Fevers [ ] Nausea [ ] Vomiting

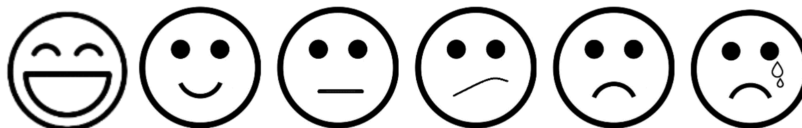
[ ] **Numbness or Tingling? Please list the location:** ______________________________

[ ] **Weakness? Please list the location:** ______________________________

[ ] **I have NOT recently developed any of the above conditions.**

DESCRIBE YOUR PAIN

Indicate your pain level with number, from 0 to 10. 0 = No Pain; 10 = Extreme Pain



The current pain is [ ].. **1 2 3 4 5 6 7 8 9 10**

The best pain last week is [ ] **1 2 3 4 5 6 7 8 9 10**

The worst pain in last week is [ ] **1 2 3 4 5 6 7 8 9 10**

The average pain in last month is [ ] **1 2 3 4 5 6 7 8 9 10**

Where is it the most painful? ______________________________

If the pain radiates, where does it radiate to? ______________________________

QUALITY OF PAIN

[ ] Aching [ ] Cramping [ ] Dull [ ] Hot / Burning [ ] Numbness [ ] Shock-like [ ] Shooting
[ ] Spasming [ ] Squeezing [ ] Stabling / Sharp [ ] Throbbing [ ] Tingling / Pins & Needles
[ ] Tiring / Exhausting

TIMING OF PAIN

What is the frequency of your pain? [ ] Constant [ ] Intermittent

When is the most painful? [ ] Morning [ ] Day time [ ] Evenings [ ] Midnight

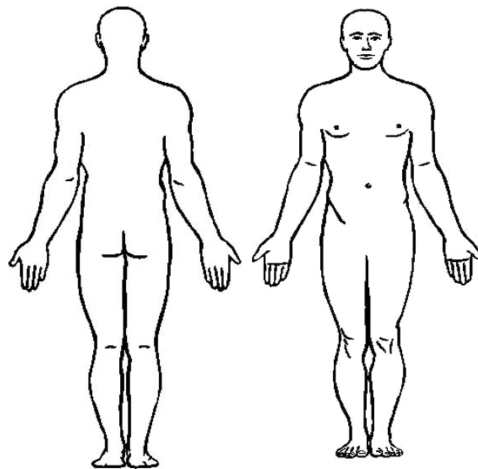
ACTIVITIES NEGATIVELY AFFECTED BY PAIN

[ ] **Enjoyment of Life** [ ] General Activity [ ] Mood [ ] Normal Work
[ ] Recreational Activities [ ] Relationships with people [ ] Sleep [ ] Walking

[ ] **Other:** ____________________

MEDICATION REGIMEN

Mark the Location of Your Pain on The Picture



Right **Left** **Left** **Right**

REVIEW OF SYSTEMS

Constitutional: [ ] Chills [ ] Difficulty Sleeping [ ] Easy Bruising [ ] Excessive Sweating
[ ] Excessive Thirst [ ] Fatigue [ ] Fevers [ ] Low Sex Drive [ ] Night Sweats
[ ] Unexplained Weight Gain [ ] Unexplained Weight Loss [ ] Weakness

Eyes: [ ] **Recent Visual Changes**

Ears / Nose / Throat / Neck: [ ] Difficulty Hearing [ ] Earaches [ ] Hay fever/Allergies [ ] Nosebleeds
[ ] Recurrent Sore Throats [ ] Ringing in the Ears [ ] Sinus Problems

Cardiovascular / Respiratory: [ ] Chest Pain [ ] Cough [ ] Fainting [ ] High Blood Pressure
[ ] Irregular Heartbeat [ ] Lightheadedness [ ] Swelling in the Feet
[ ] Shortness of Breath During exertion [ ] Wheezing

Gastrointestinal: [ ] Abdominal Cramps [ ] Acid Reflux [ ] Constipation [ ] Dark and Tarry Stools
[ ] Coffee Ground Appearance in Vomit [ ] Diarrhea [ ] Hernia [ ] Vomiting

Musculoskeletal: [ ] Back Pain [ ] Joint Pain [ ] Joint Swelling [ ] Muscle Spasms [ ] Neck Pain

Neurological: [ ] Dizziness [ ] Headaches [ ] Fainting [ ] Instability When Walking
[ ] Numbness/Tingling [ ] Seizures

Psychiatric: [ ] Anxiety / Stress [ ] Depressed Mood [ ] Suicidal Thoughts [ ] Suicidal Planning

OPIOID RISK TOOL

Name: **Age:**		Female		Male	
		Yes	No	Yes	No
Family history of substance abuse	Alcohol	1	0	3	0
	Illegal drugs	2	0	3	0
	Rx drugs	4	0	4	0
Personal history of substance abuse	Alcohol	3	0	3	0
	Illegal drugs	4	0	4	0
	Rx drugs	5	0	5	0
Age between 16-45		1	0	1	0
History of preadolescent sexual abuse		3	0	0	0
Psychological Disease	ADD, OCD, Bipolar, Schizophrenia	2	0	2	0
	Depression	1	0	1	0

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

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Total Score ____________________ **Risk Category** ______________________________

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