MOTIONORTHOPAEDICS
Jordan D. Farley,DO
P# (314)991.4342 F# (844)395.0839

FOLLOW-UP OFFICE NOTE

Please check (✓) the appropriate box(es) (☐) and fill in the blank(s) as needed.

PATIENT HEALTH QUESTIONNAIRE

PAIN ASSESSMENT

Date ofVisit: _____

1. Why are you here today? _____
2. Where is your pain? _____

3. Describe your pain:

☐ Aching ☐ Sharp ☐ Penetrating ☐ Gnawing ☐ Stabbing ☐ Throbbing ☐ Tender
☐ Nagging ☐ Tiring ☐ Exhausting ☐ Shooting ☐ Burning ☐ Numb ☐ Unbearable
☐ Miserable Other: _____

4. Frequency of your pain? ☐ Occasional ☐ Frequent ☐ Continuous
5. What time of the day is your pain the worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime
6. What makes your pain worse? _____
7. What makes your pain better? _____

Please answer the following questions using the ADL Pain Chart below:

ADL's = Activities of Daily Living (i.e. walking, house chores)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere with ADL's		Mildly interferes with ADL's		Somewhat interferes with ADL's		Partially interferes with ADL's		Greatly interferes with ADL's		Completely interferes with ADL's
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Worst Possible Pain

8. Rate your pain by the number that best describes your pain in the last week.
   Least Pain:_____ Worst Pain:_____ Average Pain:_____ Pain Right Now:_____
9. What is your pain goal in order to have quality in your life?

MEDICINES: Please list your (Pain Management Center) medicines.

✔ if new	Name of Medicine	Dose	How Often	Benefit	Side Effects
☐					
☐					
☐					
☐					
☐					
☐					

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Please list any other medications that you take.

✔ if new	Name of Medicine	Dose	How Often	✔ if new	Name of Medicine	Dose	How Often

11. Do you have any new allergies/sensitivities?
What kind of reaction did you have?

MEDICAL AND SOCIAL HISTORY REVIEW

12. Do you have any new medical problems? ☐ No ☐ Yes, explain: _____

13. Since your last visit, have you had any:

	Yes	No		Yes	No
Appetite Changes	☐	☐	Sexual Function Concerns	☐	☐
Weight Changes	☐	☐	Change in Physical Activity	☐	☐
Stomach Upset	☐	☐	Sleep Changes	☐	☐
Constipation	☐	☐	Mood Changes	☐	☐
Urinary Changes	☐	☐	Financial Concerns	☐	☐
			Family Concerns or Problems	☐	☐

	Yes	No	N/A
14. Are you taking pain medication for pain relief only?	☐	☐	☐
15. Are you concerned about addiction with pain medication?	☐	☐	☐
16. Do you feel you are addicted to pain medication?	☐	☐	☐
17. Are you going to Physical Therapy? Where? _____	☐	☐	☐
18. Are you participating in a home exercise program?	☐	☐	☐
19. Are you going to Behavioral Medicine?	☐	☐	☐
20. Are you participating in the Cognitive Behavioral Group?	☐	☐	☐
21. Did you have a procedure at your last visit?	☐	☐	☐
What benefit did you receive? _____	☐	☐	☐
22. Did you follow up with any physician you were referred to?	☐	☐	☐
Who? _____	☐	☐	☐
23. Did you have any new tests performed?	☐	☐	☐
What? _____ Where? _____	☐	☐	☐

☐ By checking this box I confirm my signature by typing it below.

___/___/___ ___:___ _____

DATE TIME PATIENT SIGNATURE