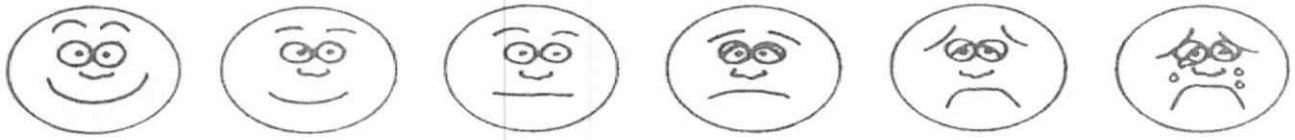
ASSESSMENT FOLLOW-UP VISIT

Date:_____ NAME:_____DATE OF BIRTH:_____AGE:_____

1. What is your preferred language? English____ Spanish___ Other____
2. Do you have any cultural, religious or emotional barriers with communication or learning? Yes__ No___
   If "Yes", please explain:_____
3. Do you have an advanced directive? Yes_____ No_____
   If "No", would you like information on Advanced Directives? Yes____ No _____
4. Have you been admitted to a hospital for overdose or pain in the last 30 days? Yes____ No_____'
5. Have you had any X-ray's, MRI's or seen any other specialist in the last 30 days? Yes_____ No_____
   If "yes", please explain:_____
6. Are you currently taking any blood thinners/anticoagulants such as Plavix or Coumadin? Yes____ No____
   If "yes", which one are you taking? Include baby aspirin:_____
7. Have you fallen within the last year? Yes_____ No_____
   If "Yes", how many falls have you had? _____ Did the falls cause injury? _____
8. WOMEN: Any possibility that you are pregnant? Yes _____ No_____
9. What is your pain level at this time? No pain(0) Mild pain(1-3) Moderate Pain(4-7) Severe Pain(8-10)



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

10. Where is the primary site of your pain? _____
11. Is there a secondary site of your pain? _____
12. What words best describe your pain (please circle): aching, throbbing, shooting, stabbing, sharp, tender, gnawing, burning, exhausting, tiring, penetrating, nagging, numb, miserable, unbearable, continuous
13. What time of day your pain is at its worse? (circle please): Morning, Afternoon, Evening, Nighttime
14. What makes your pain worse? Standing, Walking, Bending, Lifting, Other: _____
15. What makes your pain better? Rest, Heat, Sitting, Standing, Other: _____
16. Do you take Buprenorphine/Suboxone/Subutex? Yes_____ No_____
    If "yes", what is your dependence relief? No Relief Mild Relief Moderate Relief Excellent Relief
17. Please list medications, recent injections or therapies that you are receiving for pain below:

a) _____ No Relief Mild Relief Moderate Relief Excellent Relief
b) _____ No Relief Mild Relief Moderate Relief Excellent Relief
c) _____ No Relief Mild Relief Moderate Relief Excellent Relief
d) _____ No Relief Mild Relief Moderate Relief Excellent Relief

18. Please list any anti-depressants, anxiety medications or cold medicines you are taking: _____
_____

What side effects or symptoms are you having now or have had during the past week? (Please Circle)

a.	Nausea	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
b.	Vomiting	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
c.	Constipation	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
d.	Lack of Appetite	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
e.	Tiredness	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
f.	Itching	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
g.	Nightmares	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
h.	Sweating	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
i.	Difficulty Thinking	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
j.	Insomnia	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
k.	Decreased Sexual Desire	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine
1. l.	Decreased erection (Men)	None 0 1 2 3 4 5 6 7 8 9 10 Severe Enough to Stop Medicine

Date:_____ NAME:_____DATE OF BIRTH:_____AGE:_____

1. Do you use tobacco products? Yes_____ No____
   If "yes", what kind and how much daily?_____
- I. Do you drink alcohol? ? Yes_____ No____
  If "yes", what kind and how much daily?_____
- II. Do you use any illicit drugs? ? Yes_____ No____
  If "yes", what kind and how much daily?_____
- III. When was your last bone density test? _____
- IV. Any recent history of abuse or neglect? Please explain:_____
  _____

REVIEW OF SYSTEM: Check 'YES' if you have had any of these symptoms in the past 30 days?

	YES	NO		YES	NO
Fatigue			Rectal Bleeding		
Fever			Urinary Frequency		
Chills			Blood urine		
Weight Change			Burning on Urination		
Lethargy			Skin Lesions/Ulcers		
Vision Changes			Yellow Skin		
Hearing loss			Blackouts/Fainting		
Neck swelling			Headaches		
Chest pain			Dizziness		
Irregular Heartbeat			Neck Pain		
Jaw Pain			Back Pain		
Arm Pain			Hot/Cold Intolerance		
Shortness of Breath			Increased Thirst		
Coughing up Blood			Increased Urination		
Diarrhea			Anxiety		
Constipation			Depression		
Stomach Pain			Excessive Anger		
Heartburn			Easy Bruising		
Black Tarry Stools					

Have you been diagnosed with any of the following? (Please Circle): High Blood Pressure, Diabetes, COPD, Kidney Disease, Stroke, Peripheral Vascular Disease, Anxiety, Depression, Heart Disease

SUICIDE RISK ASSESSMENT (Circle yes or no)

1. Have you wished you were dead or wished you could go to sleep and not wake up within the last 30 days? YES NO
2. Have you had any thoughts of killing or harming yourself within the last 30 days? YES NO
   If 'yes' to either of the above, continue to the next section.
3. Do you have a plan for how you might do this? YES NO
4. Have you had these thoughts and had some intention? YES NO
5. Have you started to work out or worked out details on how to end your life? YES NO
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? YES NO
7. If 'yes' – was it within the past 3 months? YES NO

COMM QUESTIONAIRE

Patient Name: **Date:**

DOB: _____

	Never	Seldom	Sometimes	Often	Very Often
Please answer the questions using the following scale:	**0**	**1**	**2**	**3**	**4**
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?					
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)					
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)					
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
5. In the past 30 days, how often have you seriously thought about hurting yourself?					
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?					
7. In the past 30 days, how often have you been in an argument?					
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?					
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?					
10. In the past 30 days, how often have you been worried about how you're handling your medications?					
11. In the past 30 days, how often have others been worried about how you're handling your medications?					
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?					
13. In the past 30 days, how often have you gotten angry with people?					
14. In the past 30 days, how often have you had to take more of your medication than prescribed?					
15. In the past 30 days, how often have you borrowed pain medication from someone else?					
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?					
17. In the past 30 days, how often have you had to visit the Emergency Room?					
SUM:					

Revival
PAIN MANAGEMENT

PATIENT DEMOGRAPHIC UPDATE

DATE: _____

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE) (MAIDEN)

DATE OF BIRTH: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: HOME: _____

WORK: _____

CELL: _____

EMAIL ADDRESS: _____
OR DECLINE EMAIL ADDRESS: _____

IF YOUR INSURANCE HAS CHANGED SINCE YOUR LAST VISIT PLEASE PROVIDE US THE NEW INFORMATION AS WELL AS A COPY OF THE CARD.*

INSURANCE COMPANY: _____

SUBSCRIBER ID: _____ GROUP ID: _____

PRIMARY CARE DOCTOR: _____