**Fireweed Health Care**
**Pain F/U Visit Questionnaire**

**Name**_____ **Date**_____

Please rate your average pain **WITHOUT** medication. (no pain) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (worst pain)

Please rate your average pain **WITH** current meds. (no pain) 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (worst pain)

**Drug/Food Allergies** & reaction: _____

Any **side effects** from your pain meds? Yes No If yes, please explain: _____

My **bowel movements** are: REGULAR CONSTIPATED DIARRHEA
My BM's are: Daily Every other day 2x/week Every 5-6 days Weekly
Is this a normal frequency for you? Yes No
Have you experienced any recent changes in **bowel control**? Yes No
Have you experienced any recent changes in **bladder control**? Yes No

If female, are you **pregnant**? Yes No ***** If you become pregnant, please notify us immediately.*****

Do you use **nicotine**? Yes No If yes, how much on average daily? _____
Would you like help with quitting? Yes No Alcohol use? Yes No Caffeine use? _____

How is your **sleep**? Good Fair Poor Average hours of sleep per 24 hours? _____

Are you currently attending **Physical Therapy?** Yes No
Are you performing daily home **exercises and stretches**? Yes No
Are you doing regular **aerobic exercise or walking**? Yes No How many minutes per week? _____

Are you currently **working**? Yes No How many hours per week? _____
Are you currently **attending school**? Yes No
Are you **volunteering**? Yes No How many hours per week? _____
Are you currently **raising children** under the age of 18? Yes No

My **current medication regimen helps me** to do the following: (circle all that apply)
Walk further Going shopping Performing domestic chores
Work harder or longer at job Doing yard work Socializing with friends
Needing less help from others Interacting with family Other _____

**Discussion:** Last dose taken when? _____ If you still have meds, how much? _____
Since your last visit, any **ER/urgent care or other provider visits for a pain complaint**? Yes No
Since your last visit, have there been **changes in any of your medications**? Yes No

**SPS Questions:**
Are you taking **vitamin D3**? Yes No Are you taking **Omega-3's**? Yes No
Have you attended **Physical Therapy, had a therapeutic massage, acupuncture, chiropractic,** etc.?
Do you use any **natural medicines** known to be effective for your pain condition? Yes No
If yes, which one(s) _____
Are you using any over-the-counter or prescription **topical therapies** for your pain? Yes No
If yes, which one(s)? _____