Gulf Coast Rehab - Recovery
And Pain Management

PAIN MANAGEMENT CONSULT OR FOLLOW-UP FROM

Date: _____ **Patient's Name:** _____ **DOB**_____

DOA:_____

Vitals: Weight_____Height_____ Heart Rate _____ Blood Pressure _____

Follow up visit from DOS_____ **Follow up MRI, Prescription, Other** _____

Since your visit is your pain Better Worse Same: _____

Location of pain: Low Back ☐ **Neck** ☐ **Shoulder** ☐ **Knee** ☐

Do you have any of the following:

- ☐ **Numbness**
- ☐ **Tingling Pins & Needles**
- ☐ **Weakness**
- ☐ **Muscle spasm**
- ☐ **Tightness**

What Makes the Pain worse? _____

What Makes the Pain Better? _____

Are you still under the care of a chiropractor? Yes or No. If Yes; How many times a week? :_____

Has pain medication helped Yes or No.

ROS: Blurring Vision, Chest Pain, Problem Breathing, Stomach Irritation, Psychiatric Disorders, Depression, Constipation, Change in appetite, Chills, Fatigue, Fever, Headache, Lightheadedness, Sleep disturbance, Weight gain, Weight loss.

Physical Exam (Musculoskeletal) : Please circle any symptoms: Arthritis, Back problems, Carpal tunnel, Gout, Joint stiffness, Leg cramps, Muscle Aches, Pain in shoulders, Painful joints, Sciatica, Swollen joints, Trauma to arm, Trauma to hip, Trauma to knee, Trauma to ankle, Weakness.

Comments: _____

Plan: _____

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