Northeast Georgia
PHYSICIANS GROUP

Neurosurgery (Follow-Up Visit - Pain Survey)

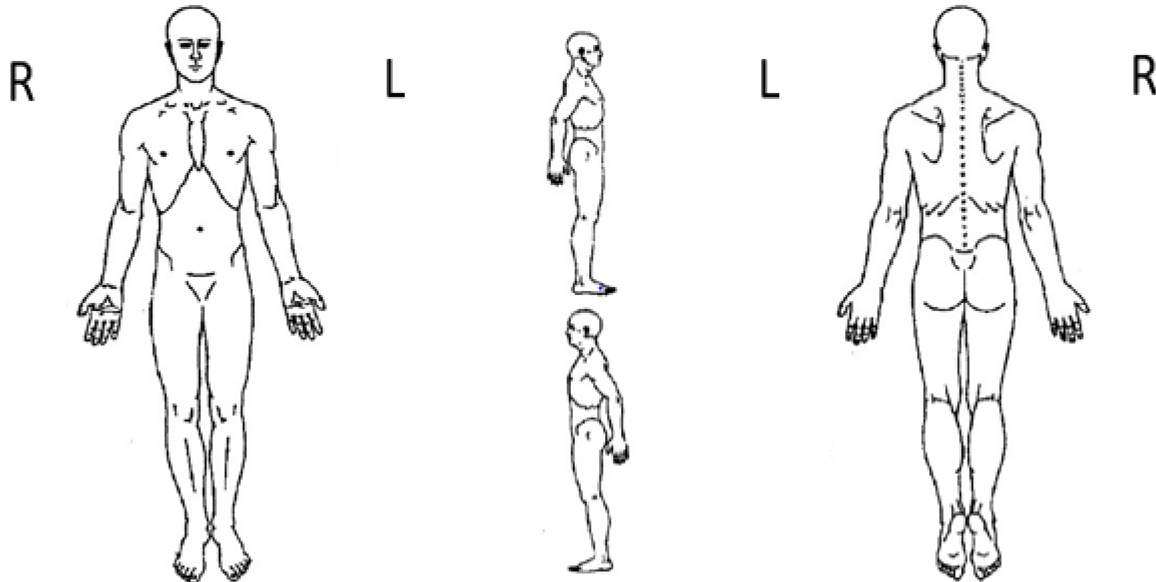
Name:___________________________________**Date:**_________________________**DOB:**__________________

Location: In what part of your body is your pain the worst? ______________________

***If you have a new provider (below) since your last visit*, PLEASE COMPLETE** (Incorrect info could delay scheduling surgery *(if needed)*)

- Primary Care Physician: _________________________ Phone # ___________________
- Cardiologist: _________________________ Phone # ___________________
- Pulmonologist: _________________________ Phone # ___________________

Please mark the area(s) of injury or discomfort on the chart below:



Describe the quality and character of your pain. (Check all that apply)

☐ Aching ☐ Burning ☐ Cold ☐ Electric Shock ☐ Hot/Flushed ☐ Numb ☐ Sharp
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Pins & Needles ☐ Dull ☐ Other (describe):________________

Rate the severity of your pain *at its worst* on this scale (1 = mild, 10 = worst pain of your life):

1.........2.........3.........4.........5.........6.........7.........8.........9.........10

Radiation/Referral Pattern: Does your pain travel to other locations? ☐ No ☐ Yes (where?______________________)

Describe the frequency of your pain. ☐ Daily ☐ Weekly ☐ Monthly ☐ Constant ☐ Infrequent/episodic/irregular

Timing: At what time of day (or night) is the pain at its worst?____

Aggravating/Alleviating Factors: What worsens the pain? __________________ What makes the pain better? ______________________

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Activity: Are you exercising, walking, stretching, etc.? ____________________

How Many Hours of Sleep do you average per night? ______ **Would you consider this quality sleep?** ☐ Yes ☐ No

How would you describe your mood? ☐ Irritable ☐ Sad ☐ Happy most of the time ☐ Other:____________________

Are you currently working? ☐ Full-Time ☐ Part Time ☐ Not Currently Working **Disability**? ☐ Yes ☐ No ☐ Pending ☐ Seeking

REVIEW OF SYSTEMS: (Check any of the following symptoms you have experienced in the **past 6 months**):

Constitutional

☐ Activity change
☐ Appetite increase
☐ Appetite loss
☐ Fever
☐ Malaise/Fatigue
☐ Weight gain
☐ Weight loss

Musculoskeletal

☐ Back Pain
☐ Difficulty walking
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Pain
☐ Neck Pain

Neurological

☐ Dizziness
☐ Weakness
☐ Headaches
☐ Light-headedness
☐ Numbness
☐ Seizures
☐ Speech Difficulty
☐ Syncope
☐ Tremors

CONSERVATIVE TREATMENTS: (Check any of the following treatments you have tried in the **past 12 months** for the area of discomfort)

☐ Physical Therapy
☐ Home Exercises
☐ Chiropractor
☐ Injections/Procedures
☐ Prior Surgery

☐ Medications/Cream
☐ Ice/Heat
☐ Massage Therapy
☐ TENS Unit
☐ Acupuncture