NPM FOLLOW UP SURVEY

NAME: _____ DOB: _____ TODAY'S DATE _____

INTERIM HISTORY & UPDATES SINCE LAST VISIT

☐ **I AM SEEKING TREATMENT FOR THE SAME PROBLEM ADDRESSED AT MY LAST VISIT**

☐ **I HAVE A NEW PAIN PROBLEM I WANT TREATMENT FOR AT THIS VISIT**

WHAT IS THE STATUS OF THE PAIN PROBLEM WE PREVIOUSLY TREATED YOU FOR?

_____

_____

DO YOU HAVE ANY NEW MEDICAL PROBLEMS SINCE LAST VISIT? ☐ NO

☐YES_____

ARE YOU TAKING BLOOD THINNERS? ☐ YES ☐ NO COULD YOU BE PREGNANT RIGHT NOW? ☐ YES ☐ NO

CURRENTLY SMOKER? ☐ YES ☐ NO SMOKER IN THE PAST? ☐ YES ☐ NO

HAVE YOU HAD ANY OF THESE SYMPTOMS RECENTLY?

☐ FEVER ☐ CHILLS ☐ FATIGUE ☐ CHEST PAIN ☐ PALPITATIONS ☐ SWELLING IN ANKLES ☐ COUGH
☐ WHEEZING ☐ SHORTNESS OF BREATH ☐ CONSTIPATION ☐ DIARRHEA ☐ NAUSEA ☐ VOMITING
☐ NUMBNESS ☐ WEAKNESS ☐ TINGLING ☐ BOWEL INCONTINENCE ☐ BLADDER INCONTIENENCE
☐ ANXIETY ☐ DEPRESSION ☐ SLEEP DISTURBANCE ☐ EASY BRUISING ☐ SWOLLEN/TENDER LYMPH
☐ JOINT AND MUSCLE PAIN

THE GOVERNMENT REQUIRES THAT WE ASK THESE QUESTIONS. WE ARE PENALIZED IF THIS SECTION IS INCOMPLETE. PLEASE RESPOND TO ALL ITEMS, EVEN IF THE QUESTIONS ARE DUPLICATED ESLEWHERE.

WHAT IS YOUR CURRENT NUMERICAL (0-10) PAIN SCORE: 0 1 2 3 4 5 6 7 8 9 10

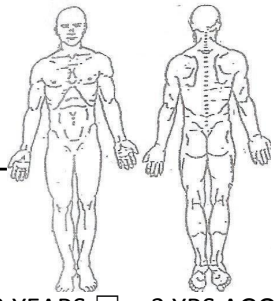
WHAT IS YOUR CURRENT HEIGHT? _____ AND WEIGHT? _____

Do you have a diagnosis of ARTHRITIS in any body region?	☐ YES ☐ NO
If you HAVE ARTHRITIS, does it interfere with activities of daily living?	☐ YES ☐ NO
Are you A FEMALE BETWEEN 65 AND 85 YEARS OLD AND HAD A DEXA SCAN?	☐ YES ☐ NO
If you are 65 OR OLDER did you receive the PNEUMOCOCCAL VACCINE?	☐ YES ☐ NO
Do you currently use ANY TOBACCO PRODUCTS?	☐ YES ☐ NO
Do you have a diagnosis of HIGH BLOOD PRESSURE?	☐ YES ☐ NO
Are you ABLE TO WALK?	☐ YES ☐ NO
In the past year have you FALLEN MORE THAN TWO TIMES?	☐ YES ☐ NO
In the past year have you FALLEN ONCE AND INJURED YOURSELF?	☐ YES ☐ NO
Do you have problems with your BALANCE?	☐ YES ☐ NO
Do you get DIZZY WHEN YOU STAND UP?	☐ YES ☐ NO
Does POOR VISION impair your balance?	☐ YES ☐ NO
Does your home have FALL HAZZARDS?	☐ YES ☐ NO
Do MEDICATIONS impair your balance?	☐ YES ☐ NO
Did you receive the INFLUENZA VACCINE THIS SEASON (OCT 1 – MAR 31)?	☐ YES ☐ NO

WHERE IS YOUR CURRENT PAIN? _____

WHAT WERE YOU REFERRED HERE FOR? _____

COLOR IN YOUR CURRENT PAIN AREAS ➡



ONSET: WHEN DID YOU <u>FIRST</u> HAVE THIS PAIN?

☐ PAST 7 DAYS ☐ PAST 14 DAYS ☐ PAST 8 WEEKS ☐ PAST YEAR ☐ PAST 1-3 YEARS ☐ > 3 YRS AGO

☐SPECIFIC DATE _____

<u>RELATED EVENT</u>

☐ NONE ☐ VEHICLE ACCIDENT ☐ FALL ☐ LIFTING INJURY ☐ SURGERY ☐ WORK ☐ OTHER

_____

<u>WORDS THAT MOST CLOSELY DESCRIBE YOUR PAIN?</u>

☐ SHARP ☐ DULL ☐ TINGLING ☐ NUMBNESS ☐ BURNING PAIN WORSE WITH ☐ WALKING
☐ STANDING ☐ SITTING ☐ BENDING FORWARD ☐ BENDING BACKWARD ☐ LAYING FLAT ☐ LIFTING
☐ COUGHING ☐ RIDING IN CAR ☐ PUSHING FOR BOWEL MOVEMENT ☐ PRESSING ON AREA
☐ PHYSICAL EXERTION ☐ NONE – PAIN IS SPONTANEOUS
☐ OTHER_____

<u>PAIN BETTER WITH</u>

☐ STOPPING ACTIVITY ☐ CHANGING POSITION ☐ REST ☐ ICE/HEAT ☐ PASSAGE OF TIME

<u>FUNCTIONAL IMPACT: DOES PAIN INTERFERE WITH ANY OF THE FOLLOWING ACTIVITIES?</u>

☐ EATING ☐ BATHING ☐ USING TOILET ☐ DRESSING ☐ GETTING UP FROM BED OR CHAIR

PAIN SCALE

0 = NO PAIN 10 = PAIN 'SUFFICIENT TO PASS OUT'

CURRENT	0	1	2	3	4	5	6	7	8	9	10
WORST IN 24 HRS	0	1	2	3	4	5	6	7	8	9	10

<u>RED FLAG QUESTIONS</u>

DO YOU CURRENTLY HAVE AN INFECTION ANYWHERE (urinary, sinus, chest, skin, etc)? ☐ YES ☐ NO
IS THERE ANY CHANCE YOU MIGHT BE PREGNANT NOW? ☐ YES ☐ NO
ARE YOU CURRENTLY TAKING A BLOOD THINNER (COUMADIN, PLAVIX, OR OTHERS)? ☐ YES ☐ NO

<u>FAILURE OF CONSERVATIVE CARE</u>

WHAT CONSERVATIVE CARE OPTIONS HAVE YOU TRIED THAT FAILED TO IMPROVE YOUR PAIN PROBLEM?
☐ REST ☐ ICE ☐ HEAT ☐ ACTIVITY MODIFICATION ☐ MEDICAL ASSISTIVE DEVICES
☐ MEDICATIONS
☐ CHIROPRACTIC ☐ PHYSICAL THERAPY (# OF WEEKS ____)
☐ PHYSICIAN SUPERVISED HOME EXERCISE PROGRAM