Texas Pain Partners

Dr. Shaun Jackson

Established Patient Follow-up Form

Patient First Name:_____ Patient DOB:_____

Patient Last Name:_____

Pharmacy (if changed)

Name: _____

Phone #: _____ **Primary**

Care Physician (if changed)

Name: _____

Phone #: _____

What is your pain status now? Worse Better Same Has it changed and how?_____

_____

Please circle on a scale of 0 to 10: (0 is no pain……10 is the worst imaginable)

At its best 0 1 2 3 4 5 6 7 8 9 10

Most of the time 0 1 2 3 4 5 6 7 8 9 10

At its worst 0 1 2 3 4 5 6 7 8 9 10

Any new diagnose(s) since your last visit:_____

Any new procedure(s) since your last visit:_____

Any new diagnostic test(s) since your last visit:_____

Any new medications or allergies since your last visit:_____

Medications

Please list medications you are currently taking for Pain:

Medication and dosage	Is it helpful?

Please list other current medications:

_____

_____

_____

_____