Texas Pain Partners
Dr. Shaun Jackson

Post-procedure Patient Follow-up Form

Patient First Name:_____ Patient DOB:_____

Patient Last Name:_____

What is your pain status now? Worse Better Same How has it changed?_____

_____

How much pain relief (%) did you receive from your procedure? _____

How long did your relief last after the procedure? _____

What activity(s) have/were you able to do differently after your procedure? _____

_____

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

Medications

Please list medications you are currently taking for Pain:

Medication and dosage Is it helpful?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list other current medications:

_____

_____

_____

_____