Maxim Moradian, M.D.
Physical Medicine and Rehabilitation
Interventional Pain Management
Sports and Electrodiagnostic Medicine

Patient Follow-up

Name:_____ **Date of Birth:** _____

Date of Service: _____

Have any of the following changed since our last visit: (circle one)

*Medical condition/Hospitalization	Yes	No
*New Diagnostic Studies	Yes	No
*Employment Status/restrictions	Yes	No

Are you currently receiving or performing any of the following treatments: (circle one)

*TENS/Interferential Current	Yes	No	
*Acupuncture	Yes	No	
*Massage Therapy	Yes	No	
*Physical Therapy	Yes	No	Name: _____
*Chiropractic care	Yes	No	Name: _____
*Independent Exercises	Yes	No	

If you recently have been participating in therapy/chiropractic/acupuncture/massage therapy, how much relief would you say you received? _____% (0-100%)

If you recently had a procedure, how much relief did you receive compared to pre-injection? _____ %(0-100%)

Please answer the following about your pain:

1. Which position **INCREASES** your pain?
   BENDING FORWARD BENDING BACKWARD REACHING LYING ON BACK LYING ON STOMACH
   SITTING ANY ACTIVITY WEIGHTBEARING STANDING WALKING CHANGING POSITIONS
   ROTATION COUGHING SNEEZING WORKING MOVING AROUND LYING ON LEFT SIDE
   LYING ON RIGHT SIDE PHYSICAL THERAPY RECENT INJECTION

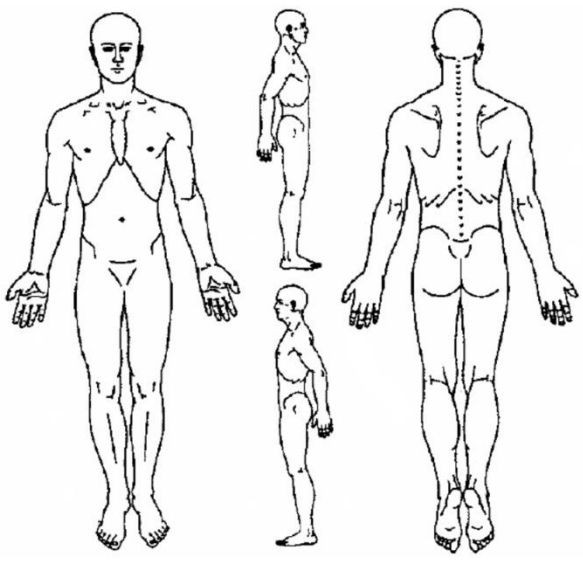
2. Which position **REDUCES** your pain?
   BENDING FORWARD BENDING BACKWARD REACHING LYING ON BACK LYING ON STOMACH
   SITTING ANY ACTIVITY WEIGHTBEARING STANDING WALKING CHANGING POSITIONS
   ROTATION COUGHING SNEEZING WORKING MOVING AROUND LYING ON LEFT SIDE
   LYING ON RIGHT SIDE PHYSICAL THERAPY RECENT INJECTION HEAT ICE

Please list any additions or discontinuations of medications since your last visit:

_____

_____

Please circle your current pain level 0 1 2 3 4 5 6 7 8 9 10
Please circle your most pain level over the last week 0 1 2 3 4 5 6 7 8 9 10
Please circle your least pain level over the last week 0 1 2 3 4 5 6 7 8 9 10



Would you **describe the pain** as: please circle all that apply: BURNING SHARP ACHING DULL THROBBING SHOOTING OTHER: (describe)

_____

_____

_____

_____

_____

_____

Please mark the figure with the location of your symptoms as a result of this injury or accident:

Pain = X Numbness/Tingling = #

CALIFORNIA SPORTS & SPINE INSTITUTE

Patient Name: _____ Room #_____

Height_____ Weight _____ B/P _____ Temp _____

PCP: _____ Referred by: _____

Please circle any of the following symptoms you have been recently experiencing:

General:	Chills	Fever	Weight Gain	Weight Loss
Skin:	New Lesions	Rash		
HEENT:	Blurred Vision	Double Vision	Hearing Loss	
Respiratory:	Cough	Wheezing		
Cardiovascular:	Chest Pain	Shortness of Breath	Abnormal Blood Pressure	
Gastrointestinal:	Abdominal Pain	Nausea		
Musculoskeletal:	Back Pain	Joint Pain	Joint Stiffness	Decreased Range Of Motion
	Joint Swelling	Muscle Pain	Muscle Weakness	Swelling of Extremities
Neurological:	Fainting	Headaches	Incontinence Stool	Incontinence Urine
	Un-coordination	Numbness	Stroke	Trouble Walking
	Unsteadiness	Weakness	Weakness in Limbs	
Psychiatric:	Anxiety	Depression		
Endocrine:	Cold Intolerance	Excessive Sweating	Heat Intolerance	
Hematology:	Abnormal Bleeding	Blood Clots	Easy Bruising	

☐ **None of the Above Apply**

STOP – DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

Last Office Visit:_____ Surgery Date: _____

Reason for visit: _____

_____

_____

_____

_____