St Luke's
Spine & Pain Associates

Allentown
501 Cetronia Road, Suite 125
Allentown, PA 18104
451 Chew Street, Suite 103
Allentown, PA 18102
Anderson Campus
1700 St. Luke's Boulevard, Suite 200
Easton, PA 18045
Bethlehem
830 Ostrum Street
Bethlehem, PA 18015
East Stroudsburg
3 Parkinsons Road
East Stroudsburg, PA 18301
Easton Hospital
250 S 21st Street
Easton, PA 18042
Lehighton
575 S 9th Street
Lehighton, PA 18235
Miners
120 Pine Street
Tamaqua, PA 18252
Orwigsburg
1165 Centre Turnpike
Orwigsburg, PA 17961
Palmerton
217 Franklin Avenue
Suite 103
Palmerton, PA 18071
Phillipsburg, NJ
Hillcrest Plaza
755 Memorial Parkway, Suite 201
Phillipsburg, NJ 08865
Quakertown
1534 Park Avenue, Suite 310
Quakertown, PA 18951
Whitehall
2363 MacArthur Road
Whitehall, PA 18052
Wind Gap
487 East Moorestown Road, Suite 110
Wind Gap, PA 18091

FOLLOW UP VISIT

Phone: (484) 526-7246

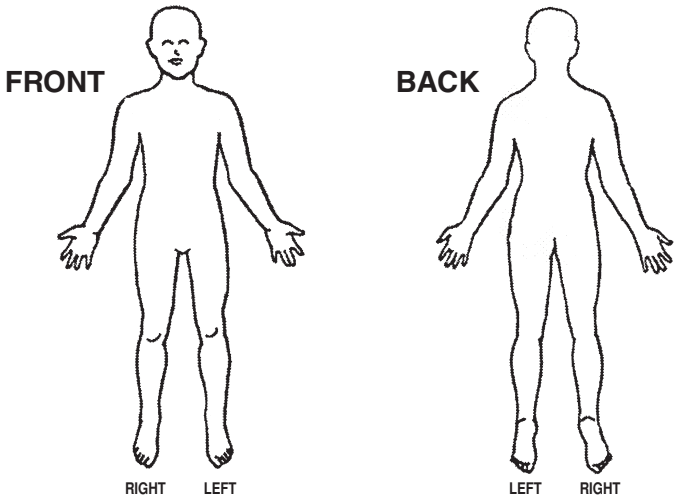
Name: _____ DOB: _____

1. Since last physician visit, are your symptoms: ☐ Better ☐ Worse ☐ Same Pain score: _____/ 10

2. If you had an injection since last visit, was it helpful? ☐ N/A ☐ No ☐ Yes
   If Yes, for _____ days / weeks / months / ongoing

3. **Describe Your Pain:** *(Please check all that apply)*
   Percentage of relief from last injection (0-100%): _____%
   My pain is: ☐ Constant ☐ Intermittent ☐ Occasional
   The quality of my pain is: ☐ Burning ☐ Dull-Aching ☐ Sharp ☐ Throbbing ☐ Cramping ☐ Pressure-like
   ☐ Shooting ☐ Numbness ☐ Pins & Needles ☐ Other *(Describe)*: _____
   Does your pain interfere with your activites of daily living (getting dressed, bathing, sleeping, cooking, etc.)?
   ☐ Yes ☐ No
   Have you been continuing conservative treatment (PT, Chiropractic, Acupuncture, Home Exercises, etc.)?
   ☐ Yes ☐ No

PLEASE INDICATE LOCATION OF PAIN ON DIAGRAM BELOW (Mark location with an X)



PLEASE COMPLETE THE BACK PORTION OF THIS SHEET

4. **Has there been any change in medications/medical/surgical history:** *(Please list the changes)*

_____ _____

_____ _____

_____ _____

5. **Review of Systems:** *(Please check all that apply)*

- ☐ Difficulty Walking
- ☐ Decreased Range of Motion
- ☐ Paralysis or Muscle Weakness
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Joint Stiffness
- ☐ Seizures or Convulsions
- ☐ Swelling *(Specify):* _____
- ☐ Pain in Extremity *(Specify):* _____
- ☐ Memory Loss
- ☐ Rash
- ☐ Shortness of Breath
- ☐ Diarrhea

6. Patient Signature: _____ Date: _____ Time: _____

Patient Printed Name: _____