KIUMARS ARFAI, M.D.
Dedicated to a Multidisciplinary Approach to Pain Management
www.painvisit.com

375 Rolling Oaks Dr. Ste 200 T: 818-359-8833 11550 Indian Hills Rd. Ste 340 Tel: (818) 361-4959
Thousand Oaks, CA 91361 Fax: 877-727-9225 Mission Hills, CA 91345 Fax: (818) 361-4951

FOLLOW-UP VISIT:

NAME_____DATE_____

Please answer the following questions to the best of your ability:

1. Chief complaint/reason for visit: _____
2. When was your last visit date? _____
3. What medications or injection were you given? _____
4. Any side effect(s) from the medications or the injection? _____
5. What is your: Height: _____ Weight: _____

Medication	**Dosage**	**Days of Supply**	**# of Pills Left**
1. **2.** **3.** **4.**			

Review of Symptoms (please circle all that apply):

Weight Loss	Weight Gain	Fever	Chills	Rash
Itching	Blurred Vision	Headache	Neck Pain	Cough
Shortness of Breath	Chest Pain	Pain On Urination	Pelvic Pain	Nausea
Vomiting	Constipation	Blood In Stools	Dark Tarry Stools	Tender Muscles
Stiff Joints	Swollen Joints	Back Pain	Numbness Arm/Legs	Numbness Legs/Feet
Weakness Arms/Hands	Dizziness	Loss of Balance	Depression	Anxiety
Poor Sleep		Other:		

6. How much improvement have you had since last visit? 0%_____100%
7. Have you received any more pain medication from another source(s) other than here?
   Yes __ No __
8. Do you drink alcohol? **Yes __No __** How much per day? _____
9. Rate your USUAL pain with current treatment: **0 _____10**
10. Mood: **GOOD__ FAIR __ DEPRESSED __ ANXIOUS __**
11. Activity Level (1-low, 5-high): **1 2 3 4 5**
12. Doing activities of daily living (ADLs): **Yes __ No __**
13. Sleep: **GOOD __FAIR __POOR __**
14. Work Status: **Retired __ Full-Time __ Not Working __**
15. Should we start to taper down your pain medications? **Yes __ No __**
16. What else did you try in addition to pain medications? **(__) Physical Therapy (__) Home Exercise (__) Chiropractor (__) TENS Unit (__) Acupuncture (__) Others _____**

Your Signature: _____