CHART #:___________________________
FOR OFFICE USE ONLY

BOULDER NEUROSURGICAL ASSOCIATES

Innovating the treatment of spine and brain disorders

FOLLOW-UP VISIT

LAST NAME:_______________________________________ **FIRST:**______________________________ **MI:**______________

PLEASE UPDATE THE FOLLOWING INFORMATION IF IT HAS CHANGED SINCE YOUR LAST VISIT:

ADDRESS:_______________________________________ **CITY:**___________________ **ST**______________ **ZIP:**__________

HOME PHONE:(______)______________**WORK PHONE:**(_____)_______________**EXT:**___ **MOBILE:**(_____)________________

EMAIL ADDRESS_______________________________________

YOUR EMPLOYER:____ **OCCUPATION:**__________________________

☐ EMPLOYED ☐RETIRED ☐ DISABLED DUE TO CURRENT CONDITION ☐DISABLED DUE TO OTHER REASONS

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME:____ **RELATIONSHIP:**____________________________

ADDRESS:_______________________________________ **CITY:**_______________ **ST:**________ **ZIP:**___________

TELEPHONE#:_(______)____________________________ **MOBILE:**_(_____)________________________________

☐ **THE ABOVE INFORMATION HAS NOT CHANGED**

HAVE THERE BEEN ANY CHANGES IN YOUR MEDICATIONS AND/OR ALLERGIES? ☐ NO ☐YES IF YES, PLEASE LIST:

____

DID YOU HAVE SURGERY PERFORMED BY BNA PHYSICIANS? ☐ NO ☐YES _______MONTHS/ YEARS AGO

HAVE YOU HAD THE FOLLOWING TREATMENTS FOR YOUR CONDITION AFTER YOUR SURGERY? (MARK ALL THAT APPLY)

☐ BRACING ☐MASSAGE ☐ PHYSICAL THERAPY ☐CHIROPRACTIC MANIPULATIONS
☐ SPINAL INJECTIONS ☐TRACTION THERAPY ☐ SPINAL CORD STIMULATOR
☐MORPHINE PUMP ☐ ALTERNATIVE MEDICINE THERAPIES ☐NONE ☐N/A

HAVE YOU HAD ANY SURGERY-RELATED COMPLICATIONS? (ONLY THE LAST SURGERY PERFORMED BY BNA PHYSICIANS) ☐ N/A ☐NO ☐ YES IF YES, PLEASE DESCRIBE ___________________________________

____

HAVE YOU RETURNED TO THE OPERATING ROOM OR WERE HOSPITALIZED BECAUSE OF COMPLICATIONS?
☐YES ☐ NO

HOW SATISFIED ARE YOU WITH THE TREATMENT YOU RECEIVED?
☐ VERY SATISFIED ☐SOMEWHAT SATISFIED ☐ DON'T KNOW ☐SOMEWHAT DISSATISFIED ☐ DISSATISFIED

HOW IS YOUR PAIN OR CONDITION THAT YOU HAD SURGERY FOR NOW COMPARED TO BEFORE SURGERY?
☐ MUCH BETTER ☐BETTER ☐ SAME ☐WORSE ☐MUCH WORSE

WOULD YOU HAVE SURGERY AGAIN FOR THE SAME CONDITION?
☐ DEFINITELY YES ☐PROBABLY YES ☐ DON'T KNOW ☐PROBABLY NO ☐DEFINITELY NO

DID YOU HAVE SURGERY DONE AS AN OUTPATIENT PROCEDURE?
☐NO ☐ YES IF YES, WOULD YOU DO IT AGAIN____

SIGNATURE:____ **DATE:**____________________________

CHART #:_____________________________
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LAST NAME:____________________________________ **FIRST NAME:** _____________________________ **MI:** ______ **AGE:** _____

PLEASE CIRCLE THE NUMBER THAT BEST INDICATES THE LEVEL OF YOUR **CURRENT PAIN**

LOW BACK PAIN	**NO PAIN**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**SEVERE PAIN**
LEG PAIN	**NO PAIN**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**SEVERE PAIN**
NECK PAIN	**NO PAIN**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**SEVERE PAIN**
ARM PAIN	**NO PAIN**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**SEVERE PAIN**
OTHER PAIN (____________)	**NO PAIN**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**SEVERE PAIN**

ARE YOU EXPERIENCING THE FOLLOWING SYMPTOMS:

☐WEAKNESS IN YOUR ARMS ☐ LEGS ☐ ARMS ☐ LEFT ☐ RIGHT

☐DIFFICULTIES WITH BOWEL AND/ OR BLADDER

IF YOU ARE EXPERIENCING NECK, LOW BACK, ARM, LEG OR OTHER PAIN, PLEASE ANSWER THE FOLLOWING:

PLEASE MARK THESE DRAWINGS ACCORDING TO WHERE YOU HURT USING THE KEY BELOW TO ILLUSTRATE THE CHARACTER OF YOUR PAIN. MARK A CIRCLED "X" IN THE ONE PLACE YOUR PAIN IS MOST SEVERE.

SHOOTING-STABBING	**BURNING / ACHING**	**PINS & NEEDLES**	**NUMBNESS**
///////////	/\/\/\/\/\	+++++++	oooooo