

# SPINE & NEUROSURGERY ASSOCIATES

A Medical Corporation  
B. Barry Chehrazi, M.D., F.A.C.S.  
Kavian Shahi, M.D., Ph.D.  
Hamid Aliabadi, M.D.

## Patient Follow Up Questionnaire

Patient Name: \_\_\_\_\_

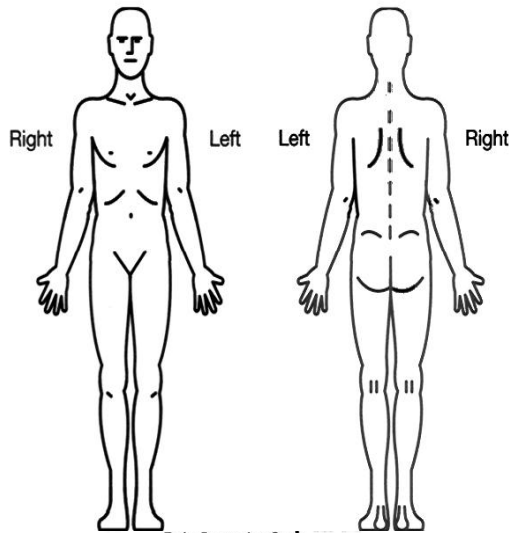
Date: \_\_\_\_\_

Your Current Primary Care Physician: \_\_\_\_\_

Please describe your current symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

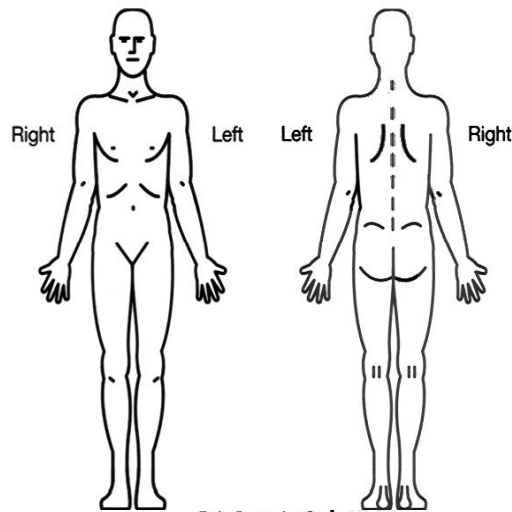
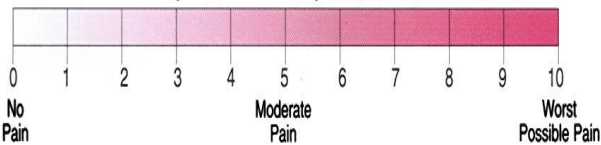
Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol.

Aching △△△△	Numbness =====	Pins & Needles 000	Burning xxx	Stabbing ///	Other ●●●●
<b>Before Surgery</b>			<b>After Surgery</b>		



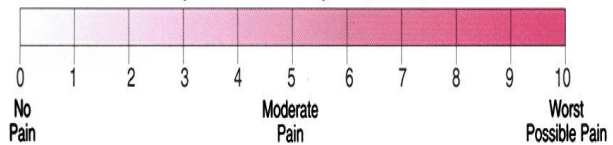
**Pain Intensity Scale**

Circle the area on the scale below that best describes how the patient rates the intensity of the pain that they are experiencing; "0" being no pain and "10" being worst possible pain.



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Please describe when you are having the above sensations: \_\_\_\_\_  
\_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

**Work Status:** \_\_\_\_\_