|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient name:** |  | | | | **Date:** | |  |
| **Primary Care Physician:** | |  | | **Referring Physician:** | |  | |
| **Pharmacy Name and Location:** | | |  | | | | |

What is the main reason for today’s visit?

Auto accident  Injection  MRI review  New issue

Other, please specify:

Are you **currently** using any of the following (check all applicable):

Back Brace

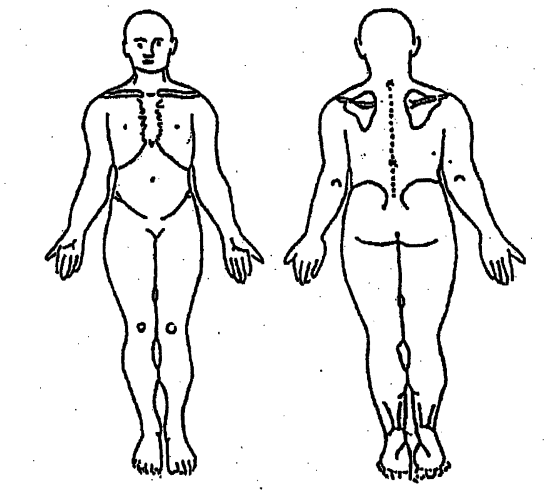
Chiropractor

Cane

Physical Therapy

Walker

Please mark an **(X)** where you are currently having pain.



Left

Right

Left

Right

How would you describe the pain?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Type of Pain** | **Location** | | **Type of Pain** | **Location** | **Type of Pain** | **Location** |
| Burning |  | | Numbness |  | Sharp |  |
| Cramping |  | | Pins, needles |  | Shooting |  |
| Dull, aching |  | | Pressure |  | Throbbing |  |
| Other, please specify: | |  | | | | |

Circle the current level of pain that you are experiencing.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No pain | | | |  | | | Severe pain | | | |
| Without Medications | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With Medications | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Percent of overall improvement since last procedure/visit? %

**PLEASE COMPLETE THIS INFORMATION EACH VISIT.**

|  |  |  |
| --- | --- | --- |
| **Medication Related to Pain**  **(Include all muscle relaxers, anti-inflammatories, nerve pills, OTCs.)** | **What times of day is it taken?** | **Refill Needed?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Please provide a COMPLETE LIST OF YOUR MEDICATIONS to the front desk.**

If you have any new medical issues or doctor visits since last visit, please identify.

Please check the items that you are currently experiencing.

|  |  |  |
| --- | --- | --- |
| **Signs & Symptoms** | **Yes** | **No** |
| Night sweats |  |  |
| Fever or chills |  |  |
| Unplanned weight loss |  |  |
| Unplanned weight gain |  |  |
| Easy bruising |  |  |
| Easy bleeding |  |  |
| Rashes |  |  |
| Low platelet count |  |  |
| Changes in vision, taste, hearing, smell |  |  |
| Difficulty breathing |  |  |
| Shortness of breath |  |  |
| Wheezing |  |  |
| Palpitations (awareness of fast heart) |  |  |
| Chest pain |  |  |
| Abdominal pain |  |  |
| Nausea |  |  |
| Vomiting |  |  |
| Diarrhea |  |  |
| Incontinence of bladder or bowel |  |  |
| Back pain |  |  |
| Neck pain |  |  |
| Joint pain (knee, elbow, hip, shoulder, etc.) |  |  |
| Muscle spasm |  |  |
| Loss of consciousness or blackouts |  |  |
| Memory loss |  |  |
| Muscle weakness |  |  |
| Seizures |  |  |
| Trouble walking |  |  |
| Dizziness |  |  |
| Headaches |  |  |
| Difficulty falling or remaining asleep |  |  |
| Difficulty concentrating |  |  |