

Name _____ DOB# _____

Please complete if changed since last visit:

Home Phone _____ Cell Phone _____ Work Phone _____

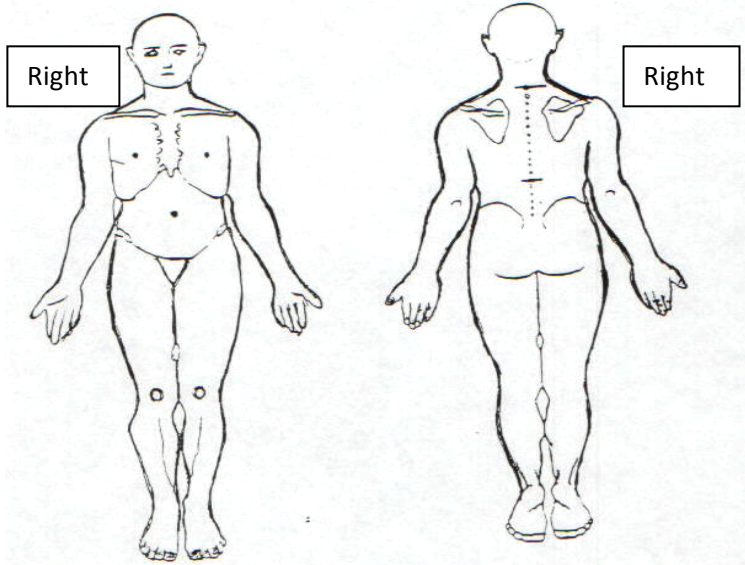
Home Address: _____

Primary Care Physician _____ Surgeon _____

Still Smoking: _____ Quit smoking since last visit: _____ Never Smoked: _____

Pain Diagram: (Shade specific areas of pain)

FOR OFFICE USE ONLY



Referring Physician:
Height:
Weight:
Blood Pressure: /
PO ₂ :
Heart Rate:
Temp:
LBP: Y N
Allergies:
Pharmacy:
E-Mail Address:

Pain Score Today: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

Has the pain changed since your last visit? Better Worse No Change

If you had a recent procedure: What type and when? _____

How much relief did you get? 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Pain Medications: Please list all pain medications you are taking (even if there are no changes)

Have there been any changes to your medications (dose, amount, stopping, new medications)?

Side effects from your medications? Nausea, Constipation, Dizziness, Weight Gain, Confusion, Other?

What does the pain feel like? Dull Throbbing Aching Sharp Electric Burning Other?

What makes your pain worse? Sitting Walking Bending Laying Down Bad Weather Other?

Does your pain have any of the following associated factors?

Bladder/Bowel Incontinence Weakness Tingling/Numbness Fever/Chills

Any new allergies, medical problems or surgeries since your last visit? Yes No (if yes please explain)