Date of visit: _____

Patient: _____ Date of birth: _____

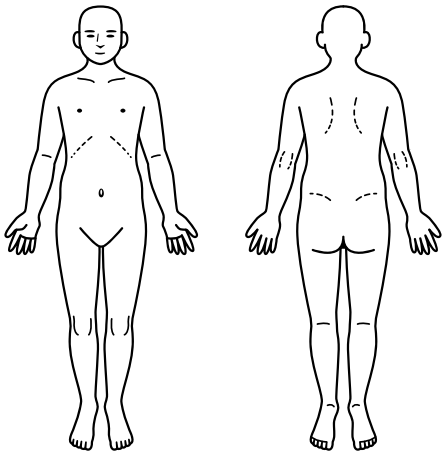
Pain / Chief Complaint: _____

Have you had this pain treated by (circle all that apply): Another Physician Urgent care center Emergency room Hospital

Were you referred to our clinic by another physician? If so, whom? _____

Medical records: ___ Have in hand today ___ Already faxed ___Will request ___ No medical records

Where is it located: (Shade diagram, mark worst spot with an X)



PAIN SCALE

Over the last week, rate:

	None										Worst
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

Office use only:

Weight: _____

Height: _____

Pulse: _____

Resp: _____

BP: _____ / _____

Pulse Ox: _____

Taken by: _____

Office use only: MODI ____ / ____ ____% SOAPP ____/ 20 No Low Mod / High

UA POC Required / Done BDI ____ GENE Pending / Done

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

How would you describe your pain? (**Circle all that apply**) Sharp Dull Aching Burning Shooting Stinging Stabbing Throbbing Numb Tingling Pressure Nagging Gnawing Shocking Crampy

When did this pain begin? _____ Onset? Sudden Gradual

Frequency of pain? Constant Intermittent

When is pain at its worst? Mornings During the day Evening Night

Since your pain began, how has it changed? Worsening Improving Stayed the same

What makes the pain worse (**Circle all that apply**)

Coughing Lifting Sitting Standing Walking Climbing stairs Lying down Other: _____

What makes the pain better (**Circle all that apply**) Ice Heat Rest Lying supine Stretching NSAIDs Opioids Physical therapy Acupuncture Chiropractor Other: _____

Does your pain interfere with your: (**Circle all that apply**) General Activity Mood Walking Work Housework Activities of daily living Hobbies Relationships Sleep Life enjoyment

Associated symptoms: (**Circle all that apply**) Depression Anxiety Sleep problems Weight gain Decreased libido Social withdrawal Loss of strength Loss of flexibility Fever Malaise Weight loss

Is this related to a specific injury? Yes No When was the injury? _____

Where did the injury occur? Home Work Auto Other: _____

What was the mechanism of the injury? Fall Bending Lifting Twisting Trauma Other: _____

Who has treated this pain?

PCP(name) _____ Phone number _____

Neurologist (name) _____ Phone number _____

Neurosurgeon (name) _____ Phone number _____

Orthopedic (name) _____ Phone number _____