Date:

Patient Name:_____________________________________ Date of Birth _____/_____/_____
Age______ Phone Number:__________________ City_________________

Regular doctor:__________________________ City:________________

Using Pain Scale of 0-10.**Rate your pain since your last visit.**
0=No pain 10=worst pain ever

At its Worst:	0	1	2	3	4	5	6	7	8	9	10
At its least:	0	1	2	3	4	5	6	7	8	9	10
At its usual:	0	1	2	3	4	5	6	7	8	9	10
Today:	0	1	2	3	4	5	6	7	8	9	10

Since your last visit how has your pain been? please circle one**:**

Worse Same Better

How have the following affected your pain since your last visit?

B=makes better W=makes worse N=no effect

Relaxation	B	W	N	Standing	B	W	N
Heat	B	W	N	Walking	B	W	N
Cold	B	W	N	Lying Down	B	W	N
Alcoholic Drinks	B	W	N	Exercise	B	W	N
Medication	B	W	N	Sexual Activity	B	W	N
Sitting	B	W	N	Coughing/Sneezing	B	W	N

Please list all pain medications and other medications bellow:

☐ Check box if there has been **no change** to your medications since your last visit.

List all PAIN medications:

Medication	Dose	Frequency	Prescribing Physician

List all other medications, including over the counter medications, vitamins and herbal supplements:

Medication	Dose	Frequency

Do you take any blood thinning medications such as Plavix, Coumadin, Warfarin, Aggrenox, Heparin or Aspirin?

Y N If yes, please list:____

Do you **currently** have any of the following symptoms?

Symptom	Y	N
Fever	Y	N
Weight loss	Y	N
Weight gain	Y	N
Night sweats	Y	N
Chills	Y	N
Malaise	Y	N
Dry eyes	Y	N
Vision change	Y	N
Wear glasses	Y	N
Hearing loss	Y	N
Ear pain	Y	N
Nose bleeds	Y	N
Sinus problems	Y	N
Sore throat	Y	N
Dry mouth	Y	N
Snoring	Y	N
Ringing in ears	Y	N
Chest pain	Y	N
Palpations	Y	N
Ankle swelling	Y	N
Difficulty breathing	Y	N
Cough	Y	N
Wheezing	Y	N
Sleep apnea	Y	N
Abdominal pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Constipation	Y	N
GERD	Y	N
Diarrhea	Y	N
Incontinence	Y	N
Urinary pain	Y	N
Blood in urine	Y	N
Muscle aches	Y	N
Muscle weakness	Y	N
Joint pain	Y	N
Back pain	Y	N
Neck pain	Y	N
Joint swelling	Y	N
Skin rash	Y	N
Non healing area	Y	N
Change to hair	Y	N
Weakness	Y	N
Numbness	Y	N
Seizures	Y	N

Dizziness	Y	N	Bruising	Y	N
Migraines	Y	N	Bleeding	Y	N
Headaches	Y	N	Dry skin	Y	N
Depression	Y	N	Runny nose	Y	N
Anxiety	Y	N	Sinus pressure	Y	N
Suicidal thoughts	Y	N	Itching	Y	N
Fatigue	Y	N			