New Patient

What is the reason for your visit today?

How would you describe your pain? ___ Burning ___ Stabbing ___ Aching ___ Throbbing ___ Dull___ Pulling ___ Sharp
How often is the pain? ___constant ___ comes and goes
How long have you had this pain or problem?

How severe is the pain at its worse? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)
How severe is the pain at its least? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)
How severe is the pain today? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)

Was there an accident or event that first caused your pain? Yes / No is yes, what?

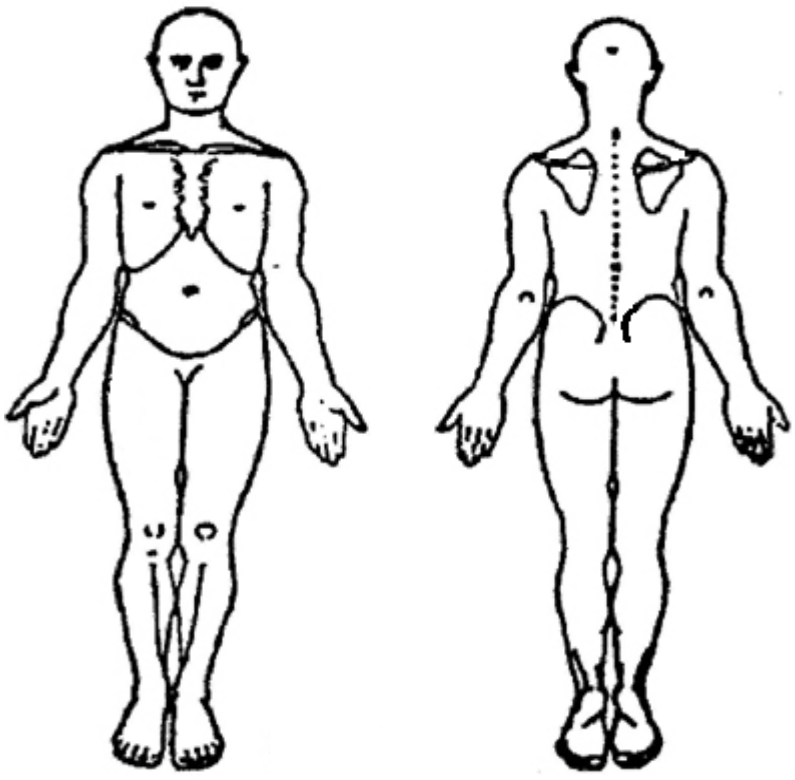
Circle any of the following treatments you have had for your pain/problem: Physical Therapy Surgery Injections
Circle any of the following studies you have had for your pain/problem: X-ray MRI CT

What makes your pain better? Rest Heat Ice Massage Stretching Applying Pressure Walking
Sitting Lying down Medication Injections Physical Therapy

What makes your pain worse? Walking Sitting Bending Stress Noise Lights Weather Changes
Turning Twisting Throwing Lifting Pressure Other:

Circle any of the following symptoms you have had recently or associated with your pain/problem:
Fever Chills Rash Lesion Swelling Weakness Numbness Tingling Poor Sleep Anxiety Depression

Using the symbols below, mark the areas of your body where you feel the described sensations.
Ache: AAA Burning: XXX Numbness: OOO Pins/Needles: . . . . Stabbing: ////



I certify that the information I have provided is true. Signature: Date:

Follow Up

What is the reason for your visit today?

List any new medications, problems or diagnosis since your last visit.

Has your pain problem improved any since your last visit? Yes / No

How severe is the pain today? (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Ever)

Circle any of the following treatments you have had for your pain/problem: Physical Therapy Surgery Injections
Circle any of the following studies you have had for your pain/problem: X-ray MRI CT

What makes your pain better? Rest Heat Ice Massage Stretching Applying Pressure Walking
Sitting Lying down Medication Injections Physical Therapy

Circle any of the following symptoms you have had recently or associated with your pain/problem:
Fever Chills Rash Lesion Swelling Weakness Numbness Tingling Poor Sleep Anxiety Depression

Using the symbols below, mark the areas of your body where you feel the described sensations.
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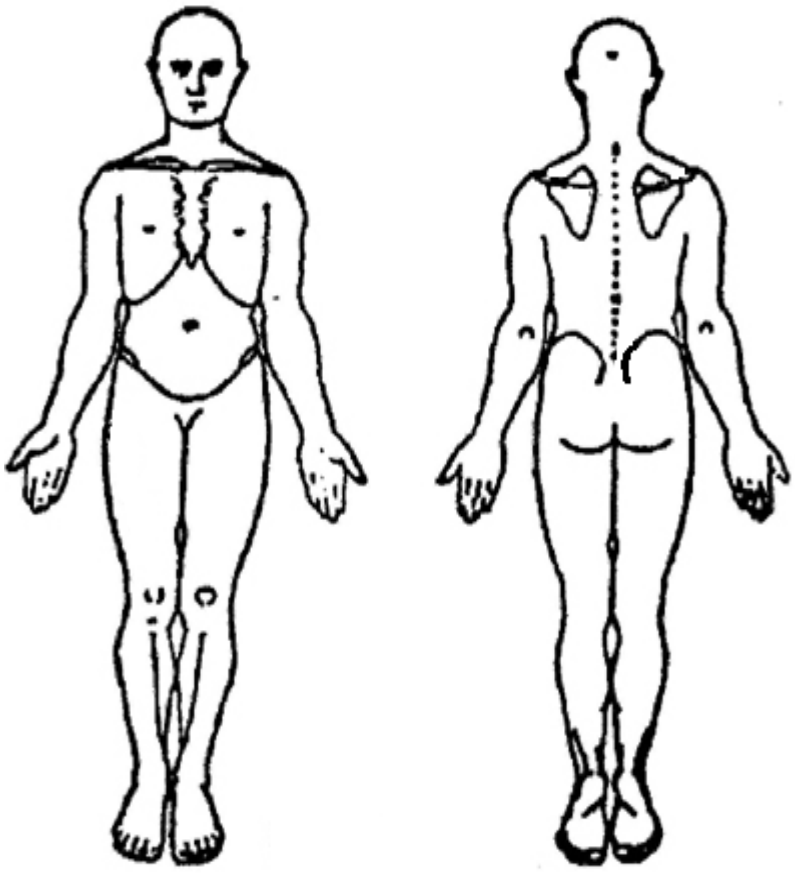

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