

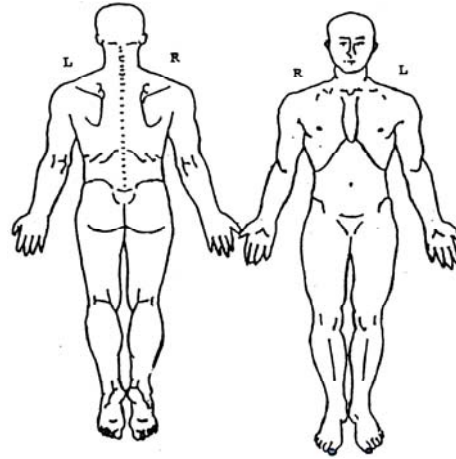
Consultants In Pain Medicine, P.A.

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Pink = Pain Blue = Numbness



Date: _____

Name: _____

D.O.B.: _____ Height: _____ Weight: _____

Primary Care Physician: _____

Please answer ALL questions below

Circle best description

1. Pain Levels TODAY: **0 1 2 3 4 5 6 7 8 9 10** (0= no pain and 10 is worst pain ever felt)

2. Pain level average over the last week: **0 1 2 3 4 5 6 7 8 9 10**

3. Is Your Pain: **Mild Moderate Severe Unbearable** (circle one)

4. Pain Quality: **Sharp, Shooting, Burning, Electrical, Dull, Aching, Throbbing**

Other: _____

5. What makes your pain better? (ie. ice, medications, rest?) _____

6. What makes your pain worse? (ie. activity, walking?) _____

7. How is your quality of sleep? **Good Fair Poor**

8. Since your last visit is your pain: **Worse Stable Improved**

9. Since your first visit is your pain: **Worse Stable Improved**

10. When do you feel your pain? **Around the clock, Mornings, Evenings, All Day, All Night,**

Random/Unpredictable

11. Do you exercise? **Yes No**

12. Has anything medically happened since your last visit? (hospitalizations, surgeries, new medications, accidents, etc.....) _____

Please list a refill of any medications needed: _____

Patient Signature: _____

Date: _____

Please place a check next to any symptom you may be experiencing: None

- | | | | |
|--------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of Feet/Ankles | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Dizziness | | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Palpitations | | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Coughing | | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Wheezing | | <input type="checkbox"/> Acid Reflux / Heartburn |

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Blood in urine or stool | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anxiety / Depression / Stress |
| <input type="checkbox"/> Burning when you urinate | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Get up more than twice a night to go to the restroom | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Any urinary incontinence (leaking of your bladder) | <input type="checkbox"/> Weakness | |
| <input type="checkbox"/> Bowel incontinence | | |