**Name:** **Date of Birth:** **Date of Service**:

**Have you been experiencing any of the following symptoms?**

Yes / No Yes/No Yes/No

❒❒ Fever, chills ❒❒ Shortness of breath ❒❒ Constipation

❒❒ Wt. ❒loss ❒ gain >10lbs ❒❒ Weakness in ❒arms ❒legs ❒❒ High blood sugars

❒❒ Blurry vision ❒❒ Numbness in ❒arms ❒legs ❒❒ Easy bruising

❒❒ Decreased hearing ❒❒ Problems walking or recent falls ❒❒ Swollen glands

❒❒ Sore throat ❒❒ Stomach pain or nausea ❒❒ Depression

❒❒ Chest pain or palpitations ❒❒ Bowel or bladder incontinence ❒❒ Anxiety

❒❒ Allergies? To what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❒❒ New rash or lesion

Allergic to: ❒Iodine or IV contrast ❒ Latex

**Have you tried any of the following therapies?**

Yes / No Yes / No

❒❒ Physical therapy ❒❒ Chiropractic manipulation

❒❒ Pool therapy ❒❒ Back or neck surgery

❒❒ TENS therapy ❒❒ Injections (Epidurals, facet blocks, joint injections, etc.)

❒❒ Acupuncture ❒❒ Pain management counseling or psychiatric therapy

❒❒ Opiate analgesics ❒❒ Non-opiate analgesics ‘



**Where is your worst pain?** On the diagram to the right, shade in the areas(s) that are painful.

❒Lower Back ❒Mid-back ❒Neck ❒Shoulder ❒Hip ❒Knee

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quality of pain**: ❒Aching ❒Throbbing ❒Shooting ❒Burning

❒Uncomfortable ❒Dull ❒Radiating ❒Sharp ❒Cramping

**Timing of pain**: ❒ Constant ❒ Intermittent

**Average pain level WITH pain medication**:

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10

**Average pain level WITHOUT pain medication**:

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10

**WORST pain level** :

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10

**BEST pain level** :

❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5 ❒ 6 ❒ 7 ❒ 8 ❒ 9 ❒ 10

**Functionality**: ❒ Limited due to pain ❒ Ambulation and activity of daily living is affected by pain

**What makes your pain better:** ❒ Rest ❒ Ice pack ❒ Heat ❒ Medication ❒ Exercise ❒ Stretching

**What makes your pain worst**: ❒ Sitting ❒ Bending ❒ Standing ❒ Lying down ❒ Lifting ❒ Walking

**Are you having trouble sleeping due to pain?** ❒ Yes ❒ No **Do you Smoke?** ❒ Yes ❒ No

**Are you currently working?** ❒ Yes ❒ No **Are you using illegal street drugs?** ❒ Yes ❒ No

**What blood thinners are you taking?** ❒NONE ❒COUMADIN ❒PLAVIX ❒PRADAXA ❒XARELTO

❒AGGRENOX ❒CILOSTAZOL ❒TICLID ❒EFFIENT ❒BRILINTA ❒APIXABAN ❒OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_