Patient Name _____

Current Pain Information

Name _____

Current Height _____ Current Weight _____

What is your current pain level?

0 1 2 3 4 5 6 7 8 9 10

Worst pain level?
0 1 2 3 4 5 6 7 8 9 10

Lowest pain level?
0 1 2 3 4 5 6 7 8 9 10

Where is your pain located today? _____ Does it radiate? (Circle One) *Yes No*

Were you injured? (Circle One) *Yes No*
How?_____

How long have you been in pain? _____

What does the pain feel like? (Circle One) *Sharp, Stabbing, Shooting, Dull, Ache, Cramp*
Other_____

Any numbness, tingling or weakness? (Circle One) *Yes No*
Where? _____

Is your pain constant or intermittent? _____

What makes you hurt more? _____

What makes you hurt less? _____

What kind of treatment have you had? _____

Are there any changes to your current medications? _____

Do you have medication allergies? _____

Do you use tobacco? If Yes, how often? _____

Do you use alcohol? If Yes, how often? _____

Primary Care Physician (Family doctor) _____ Phone _____

Pharmacy _____ Pharmacy Phone _____

CONTINUED ON BACK……

Patient Name _____

REVIEW OF SYMPTOMS

IN THE PAST 2-4 WEEKS HAVE YOU HAD ANY OF THE FOLLOWING?

Recent weight change or fever	Y	N
Blurred or double vision	Y	N
Difficulty swallowing or head colds	Y	N
Chest pains or rapid heartbeat	Y	N
Difficulty breathing or shortness of breath	Y	N
Nausea, vomiting, diarrhea, or constipation	Y	N
Hernias or testicular problems (males)	Y	N
Painful or frequent urination (females)	Y	N
Joint pain or swelling	Y	N
Rashes or changes in skin/hair/nails	Y	N
Numbness, tingling or weakness	Y	N
Depression, irritability or suicidal thoughts	Y	N
Fatigue or thirst	Y	N
Abnormal bruising or bleeding	Y	N
Hives or persistent infections	Y	N