

Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Who is your primary care physician/family doctor?

\_\_\_\_\_

*Office Use Only*

Blood Pressure: \_\_\_\_\_

Heart Rate: \_\_\_\_\_

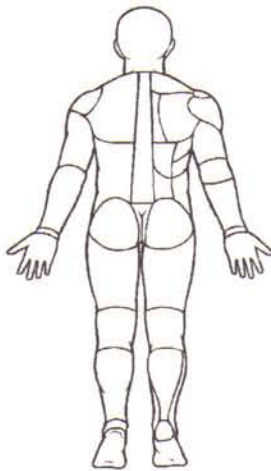
Temperature: \_\_\_\_\_

Weight: \_\_\_\_\_

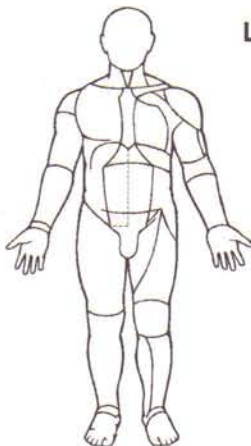
What is the major reason you are coming to see the doctor (chief complaint):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

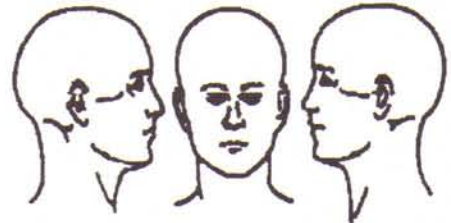
Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.



R



L



How long does the pain last?

Constant

Intermittent

**Quality Of Pain:**

Please mark all that apply:

- |  |                                      |  |                                  |                                   |
|--|--------------------------------------|--|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Throbbing       | <input type="checkbox"/> Cramping    | <input type="checkbox"/> Gnawing           | <input type="checkbox"/> Aching  | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Stabbing        | <input type="checkbox"/> Sharp       | <input type="checkbox"/> Hot-burning       | <input type="checkbox"/> Heavy   | <input type="checkbox"/> Tender   |
| <input type="checkbox"/> Splitting       | <input type="checkbox"/> Sickening   | <input type="checkbox"/> Tiring-Exhausting | <input type="checkbox"/> Fearful |                                   |
| <input type="checkbox"/> Punishing-Cruel | <input type="checkbox"/> Other _____ |  |                                  |                                   |

**Intensity of Pain:**

On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

**What makes your pain worse?** Mark all that apply.

- Bending                       Lifting                       Coughing                       Sneezing  
 Defecation                       Prolonged Sitting                       Walking                       Prolonged Standing  
 Other, please explain \_\_\_\_\_

**What makes your pain better?** Mark all that apply.

- Rest                       Activity/physical therapy                       Massage                       Heat  
 Cold                       Lying in a fetal position                       Lying on your back  
 Lying on back w/ pillows under your legs                       Medication, please list \_\_\_\_\_  
 Other, please explain \_\_\_\_\_

**Which of the following tests have you undergone prior to your arrival here today?**

- X-rays                       CAT scan                       MRI scan                       EMG test  
 Discogram                       Myelogram

**REVIEW OF SYSTEMS**

Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)

**• Constitutional**

- No Problems                       Fever                       Weight Loss                       Fatigue

**• Cardiovascular**

- No Problems                       Chest Pain/Angina                       Irregular Heart Beat                       Fainting  
 Limb Swelling                       Limb Pain on Walking

**• Genitourinary**

- No Problems                       Incontinence                       Pain on Urination                       Blood in Urine

**• Musculoskeletal**

- No Problems                       Muscle Pain                       Muscle Cramp                       Neck Pain                       Back Pain  
 Joint Swelling                       Joint Pain                       Joint Stiffness                       Muscle Twitches

**• Neurologic**

- No Problems                       Headache                       Weakness                       Tremors                       Seizures  
 Trouble with Memory/Concentration                       Blackouts                       Face Numbness/Pain

**• Psychiatric**

- No Problems                       Hallucinations                       Feeling Down                       Trouble Sleeping  
 Suicidal Thoughts                       Inappropriate Crying/Laughing

**• Hematologic/Lymphatic**

- No Problems                       Abnormal Bleeding                       Anemia                       Lumps/Swellings