Patient ID: **Date:**

Name: _____

Reason for Visit: _____

Work status: Full Time / Part Time / Retired / Disabled

List any procedure(s) from last appointment to now: _____

List any change(s) in medication(s) from last appointment to now: _____

_____

List any pain medication(s) you are currently taking, how much, and how often: _____

_____

List any side effect(s) from your pain medication(s)? _____

_____

Since my last appointment, my pain is _____% better / worse / unchanged.

Pain level (from 0 to 10 with 0's being no pain and 10's being worst pain in life):

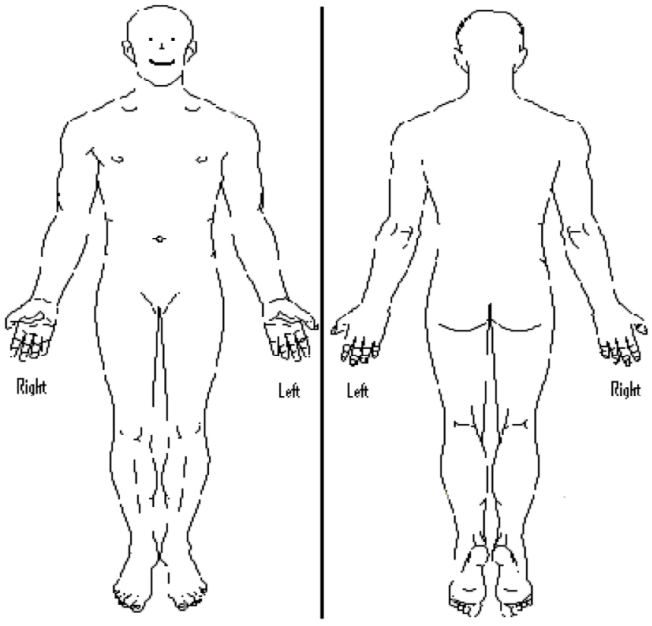
Right now:	0 1 2 3 4 5 6 7 8 9 10	Average over past 2 weeks:	0 1 2 3 4 5 6 7 8 9 10
Best during past 2 weeks:	0 1 2 3 4 5 6 7 8 9 10	Worst during past 2 weeks:	0 1 2 3 4 5 6 7 8 9 10

Is there any new:	Bowel accidents:	Y / N	Bladder accidents:	Y / N
	Sensory loss:	Y / N	Muscle weakness:	Y / N
	Change in sleep:	Y / N	Change in mood:	Y / N
	Change in activity:	Y / N	Hospitalizations/ER/urgent care:	Y / N

Review of Systems: (Circle all that apply) Black stools / Bloody stools / Bruising / Chest pain / Constipation / Cough / Decreased sex drive / Diarrhea / Difficulty urinating / Dizziness / Double vision / Fatigue / Fever / Heat or cold intolerance / Nausea / Rash / Recent memory loss / Ringing in the ears / Seizure / Shortness-of-breath / Suicidal thoughts / Unplanned weight loss / Vomiting / Wheezing

Please draw the location and quality of your pain:

O – Numbness X – Stabbing + -- Burning
^ -- Aching T – Throbbing * -- Shooting



Vital Signs (Office use):

Height: _____ Weight: _____

Heart Rate: _____ Blood Pressure: _____