SOUTHWEST PAIN MANAGEMENT
Relief begins here.

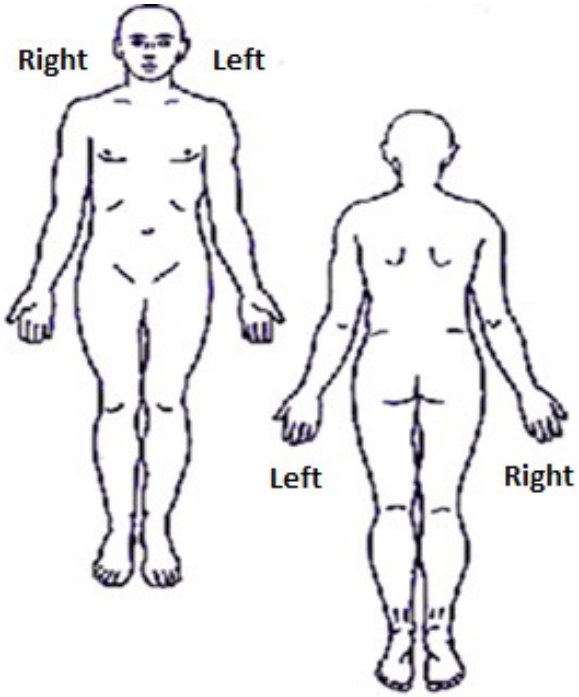
Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Reason for Today's Visit (Mark ALL that apply)

☐Medication Refill
☐Procedure Follow Up
☐Neck Pain
☐Low Back Pain
☐Mid Back Pain
☐Facial Pain
☐Leg Pain
☐Shoulder Pain
☐Arm Pain
☐Image Review
☐Other:_____

Are your pain medications helping? ☐Yes ☐No
Improved Pain Relief: _____% (0-100%)
Functional Improvement: _____% (0-100%)
Have you stopped taking any of your medications?
Are you taking any blood thinners?

Indicate where your pain is located:



What is your pain level NOW(1-10): _____

1. Use the following letters to describe your pain.
Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle spasm = M

2. Draw arrows where the pain radiates.

Patient Signature:_____ Date:_____

Vitals:

BP: Pulse: Oxygen:

Height: Weight: Temp: