Name: ____ **Date of Birth:** ____________ **Age:** ______ **Today's Date:** ____________

HEIGHT: ______________ **WEIGHT:** ________________ **BP:** _______________ **PULSE:** _________________

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

☐Routine Follow Up
☐Review Imaging ☐Medication Problem or Change
☐Medication Refill ☐New Problem: _________________
☐Review Test Result ☐Other: _______________________

My CHIEF PAIN COMPLAINT is: (Mark only ONE)

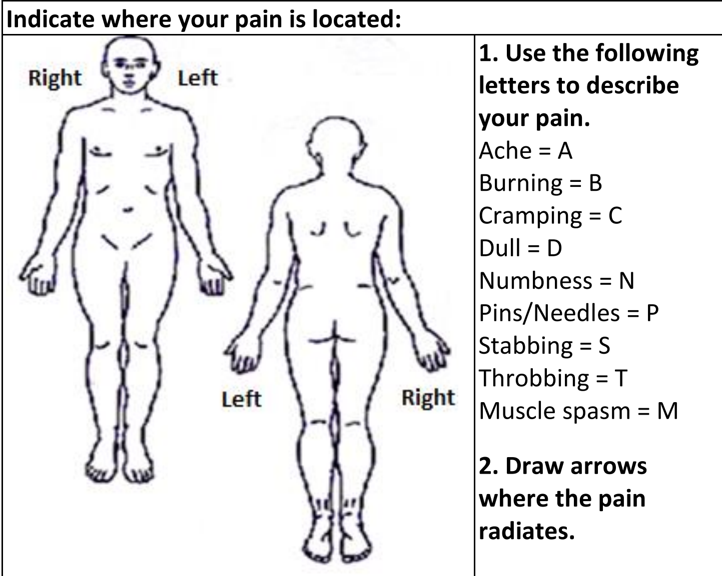
☐headache	☐neck pain	☐left arm pain
☐facial pain	☐mid-back pain	☐right arm pain
☐chest wall pain	☐low-back pain	☐left leg pain
☐abdominal pain	☐buttock pain	☐right leg pain
☐groin pain	☐tailbone pain	☐other: ____________

My ADDITIONAL pain complaint(s) is (are): (Mark ALL that apply)

☐headache	☐neck pain	☐left arm pain
☐facial pain	☐mid-back pain	☐right arm pain
☐chest wall pain	☐low-back pain	☐left leg pain
☐abdominal pain	☐buttock pain	☐right leg pain
☐groin pain	☐tailbone pain	☐other: ____________

Your pain w/ meds:	____/10	☐constant
Your worst pain:	____/10	☐fluctuating, always present
Your least pain:	____/10	☐fluctuating, usually present
Your average pain:	____/10	☐fluctuating, rarely present

Indicate where your pain is located:



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.

What makes your pain worse?

What makes your pain better?

Since your last visit, has there been any new:

☐Balance problems ☐Numbness: ☐ Arms ☐ Legs
☐Difficulty walking ☐Tingling: ☐ Arms ☐ Legs
☐Bladder incontinence ☐Weakness: ☐ Arms ☐ Legs
☐Bowel incontinence ☐Other:___________________________

Since being treated , how have the following changed:

Pain control	☐Improved	☐Unchanged	☐Worse
Function	☐Improved	☐Unchanged	☐Worse
Quality of life	☐Improved	☐Unchanged	☐Worse

List all Current Medications

Medication Name	Dose	Frequency	Prescriber Provider

Are your pain medications helping? ☐Yes ☐No

-Improved Pain Relief: _______% (0-100%)

-Functional Improvement: _______% (0-100%)

-Improved Quality of Life: _______% (0-100%)

-Are there any side effects? ☐Yes ☐No
-If 'Yes', which?

Do you have any Allergies to Medication? ☐Yes ☐No
-If 'Yes', which?

Prescription medication or illegal drug misuse/abuse or addiction: ☐ Yes, currently ☐ Yes, in the past ☐ Never

Are you receiving other treatments for your pain? ☐Yes ☐No
-Physical therapy: ☐Helpful ☐Not Helpful ☐N/A
-Chiropractic: ☐Helpful ☐Not Helpful ☐N/A
-Massage/Acupuncture: ☐Helpful ☐Not Helpful ☐N/A
-TENS Therapy: ☐Helpful ☐Not Helpful ☐N/A
-Bracing/Orthotics: ☐Helpful ☐Not Helpful ☐N/A
-Other: __________________ ☐Helpful ☐Not Helpful ☐N/A

Since your last visit, any new testing/images? ☐Yes ☐No
If 'Yes', which?

Since your last visit, any new medications? ☐Yes ☐No
If 'Yes', which?

Since your last visit, any changes in your health? ☐Yes ☐No
If 'Yes', which?

Since your last visit, other problems/concerns? ☐Yes ☐No
If 'Yes', which?

Pharmacy Information/ Changes:

Name:
Phone:
Address: