Innovative Spine and Pain Institute
Where pain stops and life begins

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PATIENT NAME: _____ DOB: _____ DATE: _____

INSURANCE: _____ PHARMACY: _____

PHARMACY LOCATION AND PHONE NUMBER: _____

(A) **WHERE IS THE LOCATION OF YOUR PAIN: _____**

(1) On a scale of 0-10, how severe is your pain?

0 1 2 3 4 5 6 7 8 9 10

(no pain) (extreme pain)

(2) Is your pain **SEVERE, MODERATE** or **MILD?**

(3) Is the pain **CONSTANT** or **INTERMITTENT**?

(4) Does the pain radiate? **YES NO**

(5) What makes the pain better? _____

(6) What makes the pain worse? _____

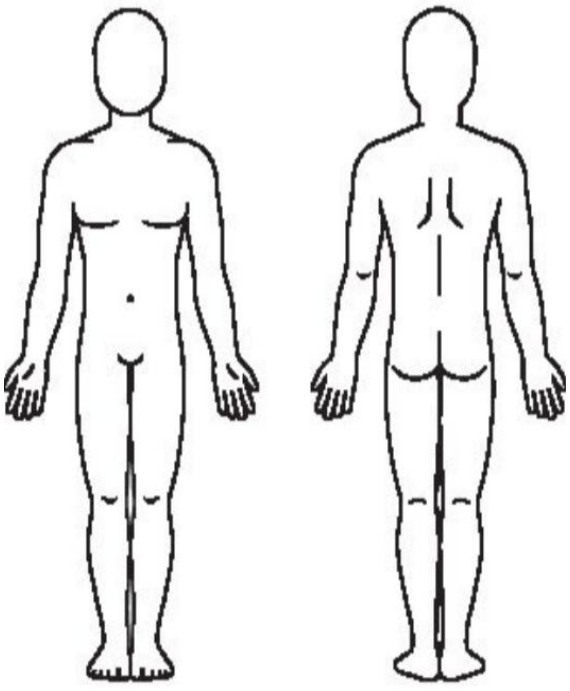
(7) How would you describe the pain?

SHARP ACHING BURNING STABBING DULL THROBBING SHOOTING ELECTRIC PINS & NEEDLES OTHER_____

(B)

- In your arms/legs, do you have any:
  - **NUMBNESS YES NO**
  - **TINGLING YES NO**
  - **WEAKNESS YES NO**
- Have you had any accidents of the:
  - **BLADDER YES NO**
  - **BOWEL YES NO**
- Have you suffered any recent fevers? **YES NO**

Please circle/shade in the area of pain



(C) Are you currently taking prescribed pain medication? **YES NO**

If so, does your pain medication improve your ability to do:

- Personal Care YES NO
- Housework YES NO
- Physical Activity YES NO
- Shop YES NO
- Social Activities YES NO
- Work YES NO

(D) Do you smoke? **Current smoker Former Smoker Never Smoked**

Do you drink alcohol? **YES NO**

Work status? **RETIRED WORKING ON DISABILITY OR APPLYING**

(E) **Have you tested positive for Covid in the last 2 WEEKS? YES NO**

(F) **Have you been exposed to anyone has tested positive for Covid in the last 2 WEEKS? YES NO**

(G) **Have you experienced any Covid like symptoms in the last 2 WEEKS? YES NO**