Name:________________________ Date:___________________ Date of Birth:________________________

Main Problem(s) Today:

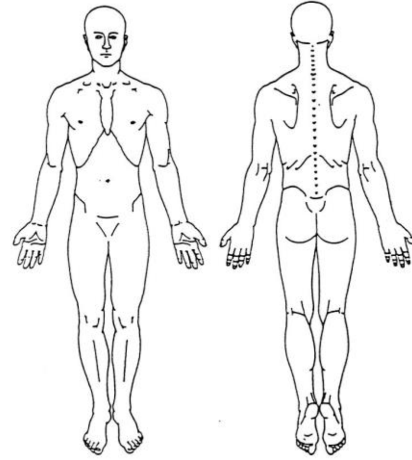
What makes your pain worse:
____

What makes your pain better:

1. ____

2. ____

3. ____



Describe your pain (circle all that apply):
Sharp, Stabbing, pinching, piercing, grabbing, aching, throbbing, shooting, burning, numbness, tingling, other:____

Circle pain level today:
1 2 3 4 5 6 7 8 9 10

____

Did you recently receive an injection since our last encounter?
☐Yes ☐No, if yes what percent relief from your usual pain did you receive? _________%

Review of Systems: please check all that apply
Constituational: ☐ Fever ☐ Weight loss ☐ rigors/shaking chills ☐ fatigue
Gentiourinary: ☐ Urinary retention ☐ urinary incontinence
GI: ☐ Constipation ☐ Diarrhea ☐ nausea/vomting ☐ GI bleeding/ulcers
Neurological: ☐ Numbness/tingling/pins/needles ☐ Weakness (location: _______)
☐ Headache
Heme: ☐ Anticoagulation (plavix, aspirin, aggrenox, coumadin, lovenox, heparin, pradaxa, arixtra)
Immunologic: ☐ Allergy (IV contrast, latex, local anesthetic)
Psycholocial: ☐ Depression ☐ anxiety

Functional capacity:
How far can you walk: ___________
Does your pain affect your ability to:

Bath yourself	YES	NO
Cook	YES	NO
Clean your house	YES	NO
Dress yourself	YES	NO
Sleep	YES	NO

Please list all pain medications being taken presently:
____