

Patient Information

Patient Name _____ Date _____
 Height _____ Weight _____ Primary Care Physician _____
 Are you a smoker? Y N How Long? _____ How much? _____ /day/week Date stopped: _____
 Alcohol use? _____ day/week Any unexplained weight loss or gain? Y N _____
 Please list all current medications and/or supplements you take: _____

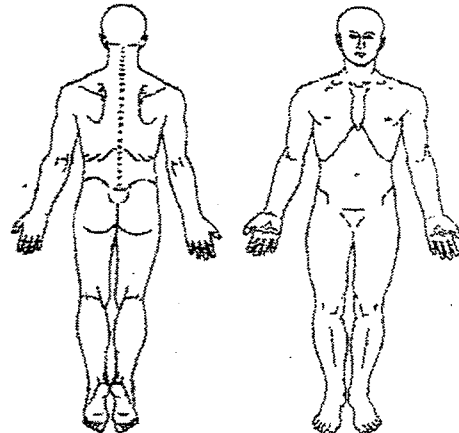
Subjective:

What is your #1 complain? _____

When did your symptoms begin? _____ Describe your symptoms as they began: _____

How often do you experience your symptoms?
 Please check:
 Constantly (76-100% of the day) _____
 Frequently (51-75% of the day) _____
 Occasionally (26-50% of the day) _____
 Intermittently (0-25% of the day) _____

Draw on the body where you have pain or other symptoms:



What describes the nature of your symptoms?
 Sharp: _____ Shooting: _____
 Dull Ache: _____ Burning: _____
 Numbness: _____ Tingling: _____

How are your symptoms changing?
 Getting better: _____
 Not changing _____
 Getting worse: _____

Does the pain stay in one place or radiate to:
 Arms Y ___ /N ___ R ___ /L ___ Legs Y ___ /N ___ R ___ /L ___

Have you noted a change to your bowels or bladder? Y / N _____

Have you used ice or heat to the painful area? Y ___ /N ___ Which? Ice ___ Heat ___

Do the symptoms get worse with Coughing Y ___ /N ___ Sneezing Y ___ /N ___ Straining Y ___ /N ___

		None										Unbearable
How bad are your symptoms at their A: worst		0	1	2	3	4	5	6	7	8	9	10
	B: best	0	1	2	3	4	5	6	7	8	9	10

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No complaints	Mild, forgotten w/activity	Moderate interferes w/activity	Limiting prevents full activity	Intense preoccupied w/ seeking relief	Severe no activity possible					