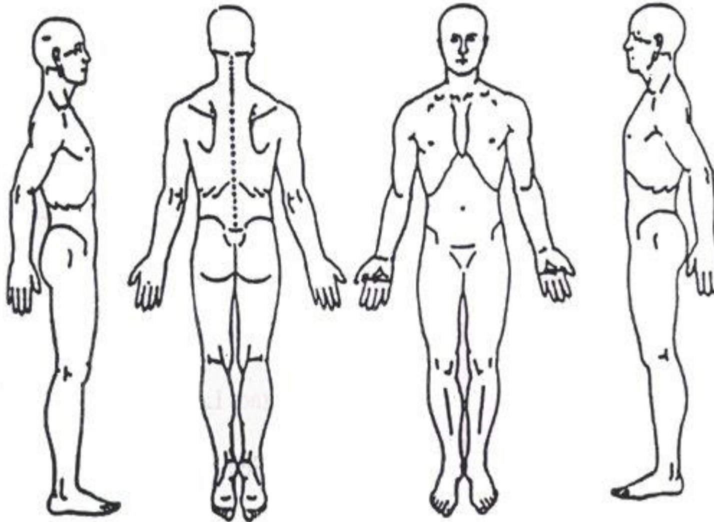
PATIENT PAIN DRAWING

NAME____ DATE OF BIRTH____________________
Date____

MARK PAIN AREA

Please circle area of pain on the drawings **BELOW.**



SEVERITY OF PAIN

1 = MINIMAL PAIN T0 10 = WORST PAIN YOU FELT

Circle the number in each area of pain

REGIONS

Neck ______________________
1 2 3 4 5 6 7 8 9 10

Headaches______________________
1 2 3 4 5 6 7 8 9 10

Mid Back ______________________
1 2 3 4 5 6 7 8 9 10

Low Back ______________________
1 2 3 4 5 6 7 8 9 10

Hips ______________________
1 2 3 4 5 6 7 8 9 10

Arms ______________________
1 2 3 4 5 6 7 8 9 10

Legs ______________________
1 2 3 4 5 6 7 8 9 10

Tell us what activities **HURT** your condition

[ ] Bending Backwards [ ] Bending Forward [ ] Bending Leg [ ] Sitting [ ] Standing

[ ] Lying Face Down [ ] Lying on Back [ ] Lying on Side [ ] Walking [ ] Driving

[ ] Stretching [ ] Stretching Leg [ ] Lifting [ ] Turning Body [ ] Turning Head

[ ] Sitting to Standing/Stand to Sit [ ] Other; Describe: ____

Symptoms are worse in the: [ ] morning [ ] afternoon [ ] night

And the symptoms: [ ] increase during the day [ ] same all day [ ] decrease during the day

When did your symptoms begin (onset date)?____

How did your symptoms begin?____

Have you received treatment for these symptoms? [ ] No [ ] Yes If so what treatment have you received _________________

____

____

Results of previous treatment? [ ] Good [ ] Poor Comments____

Do your symptoms radiate? [ ] No [ ] Yes If yes, Where?____

Has your condition? [ ] Improved [ ] Gotten Worse [ ] Stayed the same since it began

Is this condition interfering with? [ ] Work [ ] Sleep [ ] Daily Routine [ ] Recreation

Have you experienced these symptoms before? [ ] No [ ] Yes If so, When?____

____

PERSONAL HABITS

Do you smoke? [ ] Never [ ] Current ( ) Everyday ( ) Socially [ ] Former

Do you drink alcohol? [ ] None [ ] Casual [ ] Moderate [ ] Heavy [ ] Drinks Beer [ ] Drinks Wine

Do you drink caffeine? [ ] None [ ] < 3 drinks/day [ ] 3-6 drinks/day [ ] > 6 drinks/day

Drug Use: [ ] None [ ] Recreational User [ ] Addiction

Have you either gained or lost weight ranging from 10 to 20 pounds within the last 12 months? [ ] No [ ] Yes [ ] Gained [ ] Lost

Amount (if applicable) ________lbs. Are you currently dieting? [ ] No [ ] Yes

Exercise? [ ] Never [ ] Daily [ ] Weekly Do you [ ] Run [ ] Walk [ ] Swim [ ] Lift Weights

Diet: Salt Intake: [ ] High [ ] Low Fat Intake: [ ] High [ ] Low Sugar Intake: [ ] High [ ] Low Vegetarian/Vegan: [ ] Yes [ ] No

LIST ANY CURRENT MEDICATIONS

Use the back of this page if you need more space.

If you have a list of your medications, we will be happy to make a copy of it for our records.

Cardiovascular:____

Diabetic:____

Headache:____

Anti-Inflammatory / Pain Killers / Muscle Relaxers:____

Vitamins / Supplements:____

Others____

Patient Name____ Date___________________

REVIEW OF SYSTEMS

Do you experience any of the following?

GENERAL HEALTH	MUSCLE AND BONE	NERVOUS SYSTEM	
[ ] Feeling Tired	[ ] Arthritis	[ ] Balance/Coordination Trouble	[ ] Abnormal Sweating
[ ] Developmental Problems	[ ] Spine Problems	[ ] Shrinking Muscles (Atrophy)	[ ] Passing Out
[ ] Nutritional Problems	[ ] Kidney/Urinary Problems	[ ] Difficulty Talking / Tasting	[ ] Weakness Facial Muscles
[ ] Chronic Fatigue Syndrome	[ ] Pain that changes Places	[ ] Difficulty Swallowing	[ ] Memory Loss
[ ] Fever	[ ] Weak Muscles	[ ] History of Stroke or Coma	[ ] Tingling of the Face
[ ] Shortness of Breath	[ ] Skin Redness / Swelling	[ ] Pins & Needles Feeling	[ ] Seizures / Convulsions
[ ] Headaches	[ ] Paleness of Skin	[ ] History of Paralysis	[ ] Involuntary Movement
		[ ] Concussion / Blackout	[ ] Reactions to Heat or Cold
		[ ] Trouble Walking Normally	[ ] Hearing Problems
		[ ] Smelling Problems	[ ] Visual Problems

MEDICAL HISTORY

Please mark any condition that you now have or have recovered from in the past or any family history of:

[Y] = You [M] = Mom [D] = Dad

[Y] [M] [D] Headaches	[Y] [M] [D] Allergies / Hay Fever	[Y] [M] [D] Hepatitis	[Y] [M] [D] Mental Illness
[Y] [M] [D] Chest pain / Angina	[Y] [M] [D] Asthma	[Y] [M] [D] Anemia	[Y] [M] [D] Drug/Alcohol Problems
[Y] [M] [D] Hypertension	[Y] [M] [D] Bronchitis / Pneumonia	[Y] [M] [D] Depression	[Y] [M] [D] Heart Palpation /Arrhythmia
[Y] [M] [D] Gall Bladder Disease	[Y] [M] [D]Gastrointestinal Disorder	[Y] [M] [D] Cancer	[Y] [M] [D] Heart Murmurs
[Y] [M] [D] Prostate Disease	[Y] [M] [D] Incontinence	[Y] [M] [D] Diabetes	[Y] [M] [D] Stroke
[Y] [M] [D] Kidney Disease	[Y] [M] Menstrual Cramps	[Y] [M] [D] Epilepsy	[Y] [M] [D]Bowel Irregularity / Ulcer
[Y] [M] [D] Pancreatitis	[Y] [M] [D] Peripheral Vascular Disease	[Y] [M] [D]Dizziness / Fainting	

TREATMENT <u>YOU</u> HAVE RECEIVED FOR THE MEDICAL HISTORY ABOVE

[ ] Family Dr. [ ] Ortho/Neuro [ ] MRI/CT SCAN [ ] Pain Management [ ] EMG [ ] Physical Therapy [ ] Massage [ ] Other____________________

SURGERIES

____

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____

OTHER HOSPITALIZATION NOT MENTIONED UNDER SURGERIES

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Is there anything else that we need to know that is not mentioned above______________________________________

____

____

Patient Name____ Date_________________