TODAY'S DATE: ____________________

Patient's Name: ____Date of Birth: ________________

List Allergies: ____Height and Weight: ____________

Do you have Diabetes? YES or NO | Have you ever smoked? YES or NO | Have your medications changed? YES or NO

In one sentence, what is your chief complaint? ____

On a scale from Zero (0) to Ten (10), please rank your pain today. **0** is No pain, **4** is Mild, and **10** is the Worst pain in your life.

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

Describe your pain. You may write your own description if none of the choices apply.

☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull ☐ Aching

☐ Tingling ☐ Numb ☐ Shooting ☐ Electric ☐ Other

What time of day does your pain occur? You may write your own response if none of the choices apply.

☐ Morning ☐ Afternoon ☐ Night ☐ During Activity

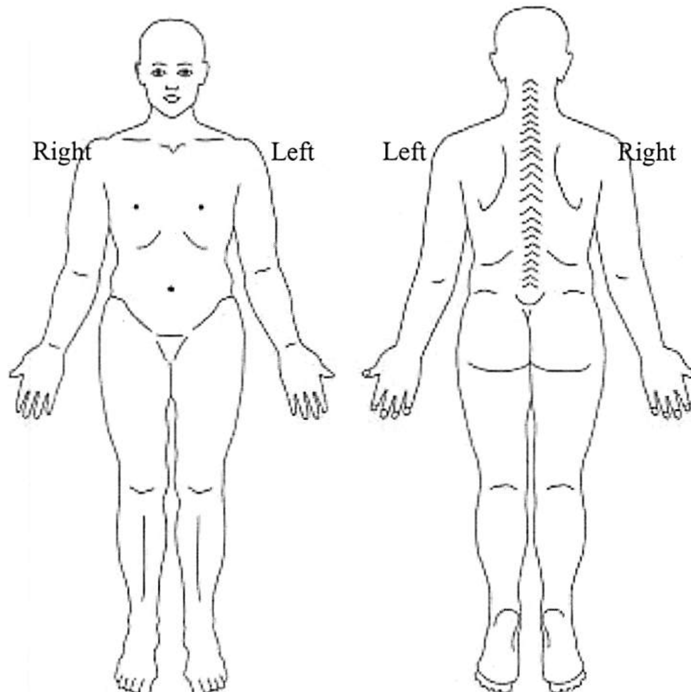
What makes your pain better?

☐ Heat ☐ Cold ☐ Rest ☐ Activity ☐ Pain Medicine

What makes you pain worse?

☐ Heat ☐ Cold ☐ Rest ☐ Activity

Mark on the diagram below everywhere you are having pain



Patient's Signature ____