

**PATIENT INFORMATION SHEET**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Sex:** M / F

**Address:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Work Phone #:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Dr's Name / Ph. #:** \_\_\_\_\_

**Date of Birth (D,M,Y):** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_

Current Health Habits	Yes	No	Patients Comments	Doctor's Comments
Did/do you smoke?				
Did/do you drink any alcohol?				
Are you concerned about your diet?				
Have you been in accidents?				
Current medications? How Long?				
Allergies?				
Exercise regularly?				
Females; Are you pregnant?				
Sleeping posture <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back				

Is there a family history of:      Heart Disease     Arthritis     Cancer     Diabetes     Other \_\_\_\_\_

**Present Complaint:** \_\_\_\_\_

Pain or problem started on \_\_\_\_\_

Pains are:      Sharp  Dull       Constant       Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with your work? \_\_\_\_    Sleep? \_\_\_\_    Daily Routine? \_\_\_\_    Other? \_\_\_\_

Is condition getting progressively worse? \_\_\_\_\_

Have you seen any other Doctors seen for this condition? \_\_\_\_\_

Any effective treatments? \_\_\_\_\_

Have you experienced any side effects from the drugs and surgeries? \_\_\_\_\_

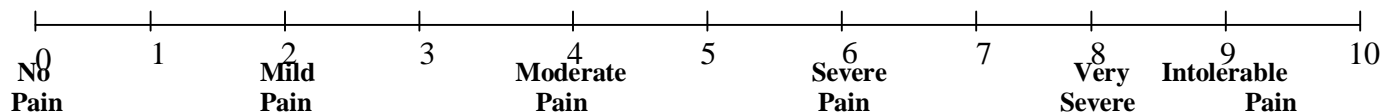
**Other Symptoms:**

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Pins and Needles in legs	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Pins and Needles in Arms	<input type="checkbox"/>	Loss of Smell
<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	Numbness in Fingers	<input type="checkbox"/>	Loss of Taste
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Numbness in Toes	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Feet Cold
<input type="checkbox"/>	Tension	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Hands Cold
<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Stomach Upset
<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Lights Bothers Eyes	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	Cold Sweats
<input type="checkbox"/>	Face Flushed	<input type="checkbox"/>	Ears Ring	<input type="checkbox"/>	Loss of Balance
<input type="checkbox"/>	Neck Stiff	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Buzzing in Ears

## Patient Pain Assessment

Name: \_\_\_\_\_  
Last
First
Date

### 0-10 Numeric Pain Intensity Scale (1)



1) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
 No Pain Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10  
 No Pain Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10  
 No Pain Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10  
 No Pain Intolerable Pain

5) What treatments or medications are you receiving for your pain? \_\_\_\_\_

6) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

**A. General activity**

0 1 2 3 4 5 6 7 8 9 10  
 Does not Interfere Completely Interferes

**B. Walking ability**

0 1 2 3 4 5 6 7 8 9 10  
 Does not Interfere Completely Interferes

**C. Normal work (includes both work outside the home and housework)**

0 1 2 3 4 5 6 7 8 9 10  
 Does not Interfere Completely Interferes

**D. Sleep**

0 1 2 3 4 5 6 7 8 9 10  
 Does not Interfere Completely Interferes

**E. Enjoyment of life**

0 1 2 3 4 5 6 7 8 9 10  
 Does not Interfere Completely Interferes