

For Office Use Only

Temp: _____

Weight: _____

Height: _____

History of Present Illness:

Chief Complaint: _____

Pain or Discomfort:

1. Rank your pain : 0 being no pain, 10 being excruciating _____
2. Location of pain:
3. Does the pain radiate anywhere? _____
4. Describe your pain:
Sharp Dull Stabbing Aching Burning Throbbing Pressure
5. How often do you have pain? (circle one)
Continuous Rarely Intermittent
6. When did your pain or condition start? _____
7. Has your pain or condition: (circle one)
Improved Not changed Worsened
8. What aggravates your pain or condition? _____
9. What have you tried to treat your pain or condition? (circle those that apply)
Medications Heat Cold Elevation Physical Therapy
Injections Surgery
10. Are you receiving any narcotic medications at this time? _____
 - a. If so, what medication are you receiving and from which doctor?

