

Patient Intake Form

Please complete the following:

Name: _____ Date _____

What is your average pain level?
 0(no pain)>10(worst pain imaginable)

Without Meds: _____

With Meds: _____

Comfort level: Poor Fair Good

Functional Status: Poor Fair Good

Since your last visit, pain is: Same Better Worse

Date of last injection: _____

Did it help? Yes No

For how long? _____

Additional Problems/Notes:

Comments/Questions for this visit:

Signature _____

Date _____

Review of Systems:

PLEASE CHECK ONLY THOSE THAT APPLY TO TODAY

<p>GENERAL:</p> <input type="checkbox"/> Weight Gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <p>SKIN</p> <input type="checkbox"/> Itching <input type="checkbox"/> New Lesions <input type="checkbox"/> Rash <p>HEENT</p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Headache <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Sore Throat <p>NECK</p> <input type="checkbox"/> Neck Pain <input type="checkbox"/> Neck Stiffness <p>RESPIRATORY:</p> <input type="checkbox"/> Cough <input type="checkbox"/> Snoring <input type="checkbox"/> Wheezing <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of Breath <p>GASTROINTESTINAL</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <p>GENITOURINARY</p> <input type="checkbox"/> Flank Pain <input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful Urination <input type="checkbox"/> Urgency <p>MALE (ONLY)</p> <input type="checkbox"/> Impotence <input type="checkbox"/> Testicular pain <p>MUSCULOSKELATAL:</p> <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Back Pain <input type="checkbox"/> Calf Pain <input type="checkbox"/> Decreased ROM <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Redness <input type="checkbox"/> Joint Stiffness	<p>MUSCULOSKELATAL:</p> <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscle Atrophy <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Swelling of Extremities <p>NEURO:</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Paresthesias <input type="checkbox"/> Unusual Sensation <input type="checkbox"/> Weakness <p>PSYCH:</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Mood Changes <input type="checkbox"/> Insomnia <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Suicidal Planning <input type="checkbox"/> Previous Suicide Attempts <p>ENDOCRINE:</p> <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Libido Change <input type="checkbox"/> Thyroid Problems
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Shade in the area where you have pain:

