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NAME: _____

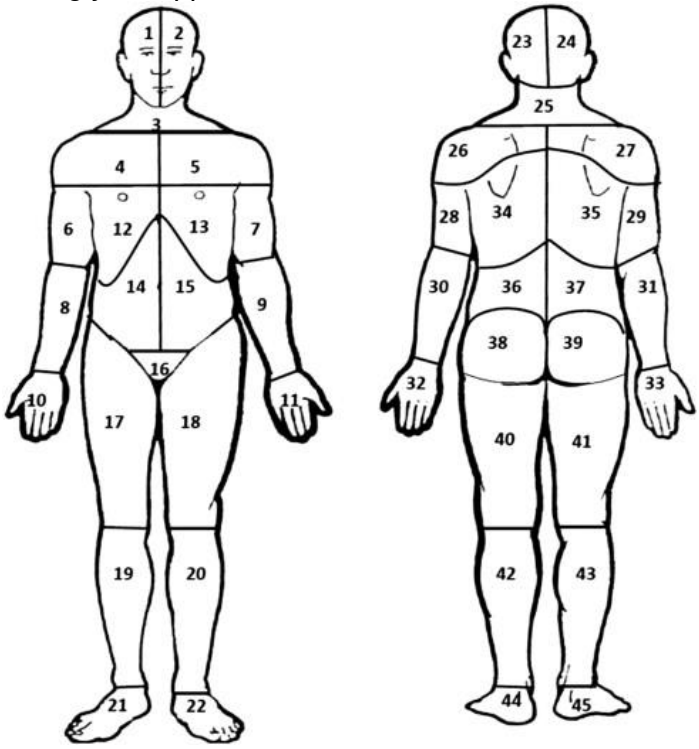
TODAY'S DATE: _____

DATE OF BIRTH: _____/ _____/_____

Question 1

Circle number closest to your primary area of complaint.

We are happy to discuss any additional areas/concerns you want evaluated/ examined during your appointment.



Question 2

Using the reference below check ☑ your current pain score for the above complaint. **Select only one number.**

0	1	2	3	4	5	6	7	8	9	10

Question 3

Is your pain... (check ☑ all that apply)
Select at least one.

☐constant? ☐episodic?

☐associated with morning stiffness?

Question 4

Check ☑ all the descriptions that apply to your primary area of complaint. **Select at least one.**

☐radiating ☐numbness ☐burning

☐aching ☐sharp ☐shooting

☐tingling/ pins and needles

Question 5

Do medications managed by this clinic improve your quality of life and/or function?

(check ☑ only one)

☐yes

☐yes, but I want to discuss medication changes

☐no ☐no medications managed by this clinic

Question 6

Circle the symptoms that have developed or changed **in the last 30 days.**
Leave blank if none apply.

Constitutional: fever, chills, night sweats, constipation, diarrhea, nausea, vomiting, unintentional weight loss **ENMT:** difficulty swallowing, dental changes **CV**: swelling, fainting **Resp:** shortness of breath, difficulty breathing **GI**: new bowel changes **GU:** new bladder changes **MSK**: pain with walking, joint stiffness, joint swelling **Neuro:** dizziness, tremors, loss of balance, new numbness, new weakness **Psych:** stress, difficulty thinking, anxiety **Endo:** hot flashes, sweating, fatigue, weight gain