

PATIENT INTAKE FORM

Name _____ DOB _____ Age _____ Sex M / F

Referring MD _____ Primary Dr. _____

CHIEF COMPLAINT: Use own words to describe why you came to clinic today _____

What are you expecting from your visit today? _____

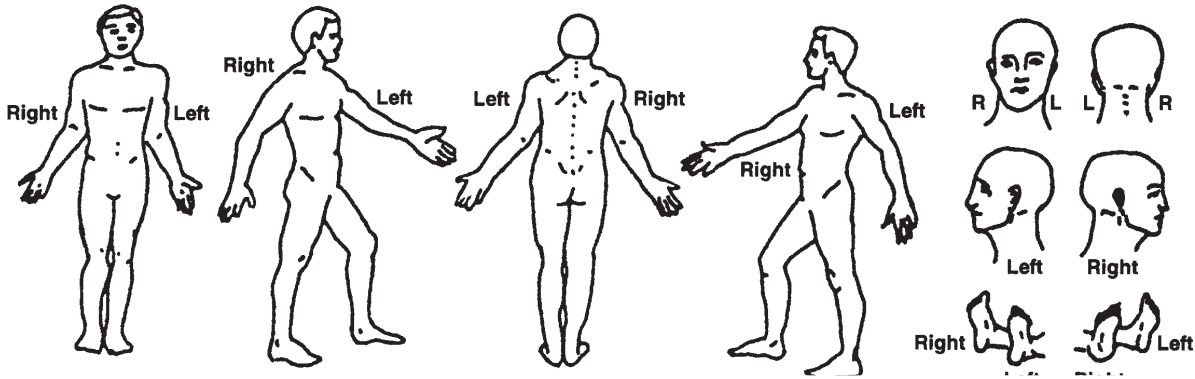
When did you first notice your pain? _____

Did your pain come on gradually overtime or suddenly one day or after injury? _____

What do you think caused your pain? (car accident, fall, work injury?) _____

Describe your pain: (i.e. on right and/or left sides, moves, sharp, dull, ache, burning, throb?) _____

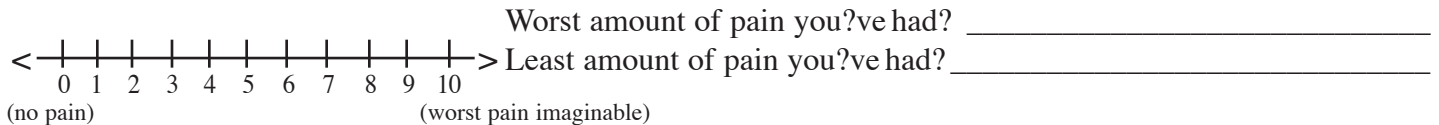
Mark the area of your pain:



Circle the level of primary pain from 0 (no pain) to 10 (worst pain imaginable):

Present level of pain **today:**

Record the number 0-10 that corresponds to your pain:



Things that make my pain better: _____

Things that cause an increase in my pain: _____

Please describe your sleeping patterns: _____

