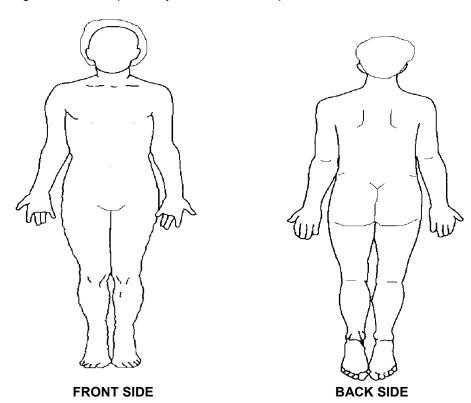
Follow up appt:

Name:	date:
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<u>PAIN DIAGRAM.</u> Mark the areas on your body where you now feel your typical pain. Include all areas. Use the following symbols below. (If you have no pain skip to next page.)

Put a large **X** over the spot that you have the most pain



PLEASE CIRCLE ALL THAT APPLY:

Since your last visit, have you had any of the following?

(please circle) MRI CT scan bone scan X-rays nerve testing (EMG)

massage PT chiropractor acupuncture injections

consult with a specialist (name) _____ none

• Pain progression since last visit? better worse unchanged

** OK to stop here, if your symptoms are unchanged **

How often do you have your pain?	con	stant		comes and goes							
Quality of pain?	stat dull	bing		ooting one	_	aching other _	bı	urning	J C	ramping	sharp
How severe is your pain at worst? (0=no pain, 10=worst pain imaginable)	1	2	3	4	5	6	7	8	9	10	
How severe is your pain at best?	1	2	3	4	5	6	7	8	9	10	

What makes the pain worse?

What makes the pain better?

Mark any of the NEW <u>symptoms</u> since your last visit. (review of symptoms)

CONSTITUTIONAL SYMPTOMS Recent weight changeFever or chillsNight sweatsLack of energy or fatigue	SKIN/BREASTRashSkin sores or ulcersBreast pain, lump or dischargenone of the above
none of the above EYES	STOMACH AND INTESTINESFrequent nausea or vomiting
Eye pain or redness	Bloody vomiting
Blurred vision or double vision	Abdominal pain
none of the above	Recurring diarrhea
	Blood in stools
EARS/NOSE/MOUTH/THROAT	Frequent or severe constipation
Hearing loss	none of the above
Ringing in ears	
Nose bleeds	NEUROLOGICAL
Difficulty swallowing	Headaches
Hoarseness	Light headedness or dizziness
none of the above	Convulsions or seizures
CARRIOVACCIII AR	Numbness or tingling in arms or legs
CARDIOVASCULAR	Weakness in arms or legs
Chest pain	Frequent falls
Abnormal heartbeat	none of the above
Shortness of breath when himselfet	DEVCHIATRIC
Shortness of breath when lying flat	PSYCHIATRIC Difficulty sleeping
Swelling of feet or ankles none of the above	Difficulty sleeping Loss of appetite
lone of the above	Loss of appetite Memory loss or confusion
RESPIRATORY	Nervousness or anxiety
Chronic or frequent coughs	Stress
Coughing up blood	Depression
Breathing problems	none of the above
none of the above	
	ENDOCRINE
GENITOURINARY	Easy bleeding or bruising
Bloody urine	Swollen glands or lumps in neck, armpits or groin
Urgency of urination	none of the above
Frequency of urination	
Painful or difficult urination	ALLERGIC/IMMUNOLOGIC
Dribbling or incontinence of urine	History of allergic reaction to:
Numbness over groin, genitalia or buttocks	Penicillin or other antibiotics
Sexual difficulties	Morphine, Demerol, or other narcotics
none of the above	Vaccines or anesthetics
	none of the above
MUSCULOSKELETAL	
Joint pain, stiffness, or swelling	OTHER (please list any other symptoms)
Muscle pain or cramps	
Increased pain with laying flat	
none of the above	
Mark any NEW conditions that you have had sinc	e your last visit. (past medical history)
High blood pressureMigraine headaches	Thyroid problemsLiver disease
High cholesterol Seizures	OsteoporosisPolio
Abnormal heart rhythmHead injury	Broken bonesCancer
Heart diseaseStroke or TIA	Arthritis or GoutChronic use of Prednisone
AsthmaDepression	Reflux or GERDIV drug use
EmphysemaFibromyalgia	Irritable bowel syndromeHIV infection
PneumoniaDrug or alcohol addiction	Stomach/duodenal ulcernone of the above
TuberculosisDiabetes	Gallbladder disease

Please list any other NEW illnesses, hospitalizations, injuries, or operations.