Follow up appt:

Name:___________________________________ **date:**_____________

PAIN DIAGRAM. **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.)**

Pain XXXXXX Numbness OOOOOO Pins and needles ////////////

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

FRONT SIDE **BACK SIDE**

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? constant comes and goes

Quality of pain? stabbing shooting aching burning cramping sharp dull none other _________________

How severe is your pain at worst? **1 2 3 4 5 6 7 8 9 10**
(0=no pain, 10=worst pain imaginable)

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 change
___Fever or chills
___Night sweats
___Lack of energy or fatigue
___none of the above

EYES
___Eye pain or redness
___Blurred vision or double vision
___none of the above

EARS/NOSE/MOUTH/THROAT
___Hearing loss
___Ringing in ears
___Nose bleeds
___Difficulty swallowing
___Hoarseness
___none of the above

CARDIOVASCULAR
___Chest pain
___Abnormal heartbeat
___Shortness of breath with activity
___Shortness of breath when lying flat
___Swelling of feet or ankles
___none of the above

RESPIRATORY
___Chronic or frequent coughs
___Coughing up blood
___Breathing problems
___none of the above

GENITOURINARY
___Bloody urine
___Urgency of urination
___Frequency of urination
___Painful or difficult urination
___Dribbling or incontinence of urine
___Numbness over groin, genitalia or buttocks
___Sexual difficulties
___none of the above

MUSCULOSKELETAL
___Joint pain, stiffness, or swelling
___Muscle pain or cramps
___Increased pain with laying flat
___none of the above

SKIN/BREAST
___Rash
___Skin sores or ulcers
___Breast pain, lump or discharge
___none of the above

STOMACH AND INTESTINES
___Frequent nausea or vomiting
___Bloody vomiting
___Abdominal pain
___Recurring diarrhea
___Blood in stools
___Frequent or severe constipation
___none of the above

NEUROLOGICAL
___Headaches
___Light headedness or dizziness
___Convulsions or seizures
___Numbness or tingling in arms or legs
___Weakness in arms or legs
___Frequent falls
___none of the above

PSYCHIATRIC
___Difficulty sleeping
___Loss of appetite
___Memory loss or confusion
___Nervousness or anxiety
___Stress
___Depression
___none of the above

ENDOCRINE
___Easy bleeding or bruising
___Swollen glands or lumps in neck, armpits or groin
___none of the above

ALLERGIC/IMMUNOLOGIC
History of allergic reaction to:
___Penicillin or other antibiotics
___Morphine, Demerol, or other narcotics
___Vaccines or anesthetics
___none of the above

OTHER (please list any other symptoms)

Mark any NEW <u>conditions</u> that you have had since your last visit. (past medical history)

___High blood pressure
___High cholesterol
___Abnormal heart rhythm
___Heart disease
___Asthma
___Emphysema
___Pneumonia
___Tuberculosis
___Migraine headaches
___Seizures
___Head injury
___Stroke or TIA
___Depression
___Fibromyalgia
___Drug or alcohol addiction
___Diabetes
___Thyroid problems
___Osteoporosis
___Broken bones
___Arthritis or Gout
___Reflux or GERD
___Irritable bowel syndrome
___Stomach/duodenal ulcer
___Gallbladder disease
___Liver disease
___Polio
___Cancer
___Chronic use of Prednisone
___IV drug use
___HIV infection
___none of the above

Please list any other NEW <u>illnesses, hospitalizations, injuries, or operations</u>.