ARIZONA PAIN
WE CHANGE LIVES HERE
a Pain Doctor Company

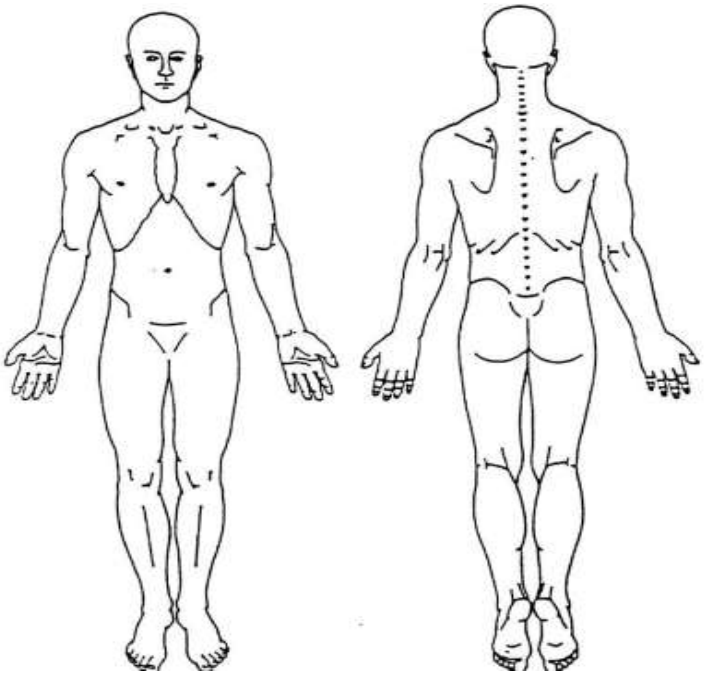
Today's Date: _____

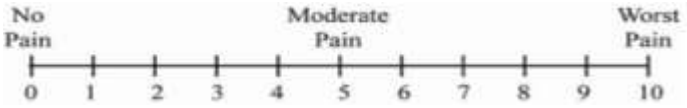
Your Name: _____ Birth Date: _____

Reason for Today's Visit: ❑ Medication Refill ❑ Medication Change ❑ Post-Procedure Assessment

❑ Review MRI/EMG or Test Results ❑ New Pain or Injury: _____

Use the diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: **"N"**umbness **"P"**ins and Needles **"A"**ching **"S"**tabbing **"B"**urning





What is your current pain level **right now**? _____

Where is your worst area of pain located? _____

_____

List any additional areas of pain: _____

_____

What word **best describes** the frequency of your pain**?**
❑ Constant ❑ Intermittent

When is your pain at its **worst?** ❑ Mornings

❑ During the day ❑ Evenings ❑ Middle of the night

Check all that describe your pain today:

❑ Aching	❑ Numb	❑ Spasming	❑ Throbbing
❑ Cramping	❑ Shock-like	❑ Squeezing	❑ Tingling/Pins and Needles
❑ Dull	❑ Shooting	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Hot/Burning			

Since Your Last Visit:

Has your pain? ❑ Increased ❑ Decreased ❑ Stayed the Same

Any new medication side effects? ❑ No ❑ Yes Please List: _____

Any new medications? ❑ No ❑ Yes Please List: _____

Any new allergies? ❑ No ❑ Yes Please List: _____

Any new imaging studies? ❑ No ❑ Yes Please List: _____

Did you have a procedure? ❑ No ❑ Yes **If yes**, how much pain relief did you obtain? _____%. Were there any problems? ❑ No ❑ Yes If yes, please explain: _____

_____

Mark the following symptoms that you <u>currently</u> suffer from:

<u>Constitutional</u>:
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Fatigue
- ❑ Fevers
- ❑ Night Sweats

<u>Eyes</u>:
- ❑ Recent Visual Changes

<u>Ears/Nose/Throat/Neck</u>:
- ❑ Difficulty Hearing
- ❑ Earaches
- ❑ Hay fever/Allergies
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

<u>Cardiovascular/Respiratory</u>:
- ❑ Chest Pain
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Swelling in the Feet

<u>Gastrointestinal</u>:
- ❑ Constipation
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Nausea/Vomiting

<u>Genitourinary/Nephrology</u>:
- ❑ Blood in Urine
- ❑ Involuntary Urination
- ❑ Loss of Bowel Control
- ❑ Painful Urination
- ❑ Pelvic Pressure

<u>Musculoskeletal</u>:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Neck Pain

<u>Neurological</u>:
- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling
- ❑ Weakness

<u>Psychiatric</u>:
- ❑ Anxiety/Stress
- ❑ Depressed Mood
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

Patient/Guardian Signature _____ Date _____