Pain Description

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

_____

What time of day is your pain at its worst? _____

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

What other factors worsen or affect your pain?

_____

What other factors relieve your pain?

_____

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc)

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist

☐ Chiropractor ☐ Orthopedic Surgeon ☐ Rheumatologist

☐ Internist ☐ Physical Therapist ☐ Neurologist

☐ Other _____

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	**Dose**	**Frequency**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			