

NAME: _____ **DOB:** _____ **DOS:** _____

Chief Complaint: in your own words, briefly describe your main problem(s) and why you are seeking care today:

Present Pain Level	Least amount of Pain last 30 days	Most amount of Pain last 30 days
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On the diagram show where most of you problems are located

PAIN SCALE

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
No pain mild Discomfort Distressing Horrible Excruciating Child Birth worst Possible

Does you pain travel? Yes No Where? _____

Do you have any numbness? Yes No Where? _____

Do you have any weakness? Yes No Where? _____

Do you have associated problems? (Select all that apply) Sexual-Dysfunction Insomnia
 Depression Loss-of-Concentration Financial Muscle Spasms Fatigue Constipation
 Other: _____

What makes you pain better? (Select all that apply) Medications Doing Less Rest Heat
 Ice-packs Injections Physical Therapy Other: _____

What makes it worse? (Select all that apply) Physical Activity Bending Standing Sitting
 Household Chores Work Duties Other: _____

Do you take each and every medication only as prescribed by the Medication Agreement form?
 Yes No

Have you had any problems with the medications since your last visit? Yes No

Which of the following have been improved by the current treatment plan? (Select all that apply)
 Pain # of Flare-ups Severity of Flare-ups Duration of Flare-ups Reduced ER Visits
 Spasms Leg Cramps Headaches Strength Endurance Depression Anxiety
 Sleep Patterns Ability to attend PT or Work Normal Daily Activities Household Chores
 Ability to Attend School Work at a Computer Prepare Meals Other: _____

I agree to bring in the prescriptions that Dr. Theesfeld is writing me in the bottles in which they were dispensed; every visit and failure to do so may result in not obtaining my medications.

I acknowledge that Dr. Theesfeld may not be available except during regular office hours and that any medical care or attention that I may require after hours may need to be taken to the emergency room or elsewhere.

I hereby verify that the above information is correct:

Signature _____ Date _____ Witness _____