Return Patient Information Form

Room #:

Patient Name: **Date of Birth:** **Today's Date:**

Since my last visit, my pain has gotten: ☐Better ☐Worse ☐Same

What is the primary reason for your visit?

☐ Medication Refill (please list medications) _____

☐ Change in pharmacy? Enter new pharmacy _____

☐ Review of Test Results (test type/location) _____

☐ Follow-Up after procedure (procedure name/date) _____

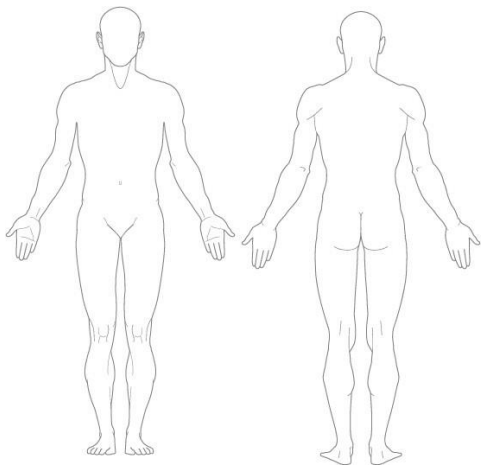
☐ Other _____

Where is your PRIMARY pain?_____

Where is your SECONDARY pain?_____

Where is your OTHER pain?_____

Please mark the location(s) of your pain:



Pain score: *(0 = no pain at all, 10 = worst pain imaginable - please circle one number)*

0 1 2 3 4 5 6 7 8 9 10

Which of the following best describes your pain?

☐Constant ☐Frequent ☐Intermittent ☐Occasional

Changes in Symptoms:

Any hospitalizations, surgeries, ER visits, since last visit?	☐Yes	☐No
Any changes to your medical history since last visit?	☐Yes	☐No
Are you experiencing any side effects on your current medications?	☐Yes	☐No
Any bowel/bladder changes since your last visit?	☐Yes	☐No
Any changes in medications since last visit?	☐Yes	☐No
Are you constipated?	☐Yes	☐No

If yes to above, please explain _____

What words would you use to describe your pain?

☐Burning	☐Throbbing	☐Dull/Aching	☐Shooting	☐Sharp
☐Cramping	☐Pressure	☐Lightening Like	☐Electric Like	☐Cutting
☐Numbness	☐Tingling	☐Insomnia	☐Other _____	