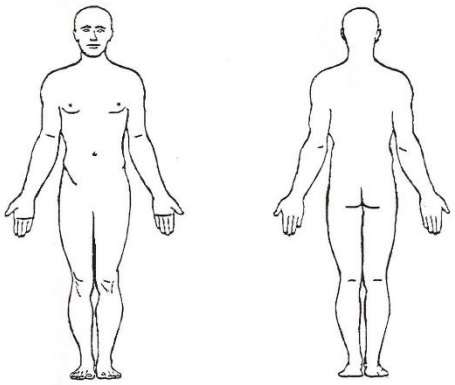
Name:_____ Date of birth:_____ Today's date:_____

Please mark where you are having pain:

- ☐ Aching
- ☐ Burning
- ☐ Sharp
- ☐ Tingling
- ☐ _____
- ☐ _____



Office Staff Only

BP_____

P _____

RR_____

O2_____

My pain is:

- ☐ Improving
- ☐ Fluctuating
- ☐ Stable
- ☐ Worse

I feel pain:

- ☐ On and off
- ☐ All the time
- ☐ Rarely

Do you smoke?

- ☐ Yes
- ☐ No

Do you take Aspirin?

- ☐ Yes
- ☐ No

If you are prescribed pain medications, what percentage of pain relief do your medications provide?_____%

What number best describes your <u>pain on average</u> in the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

How has your pain interfered with your <u>enjoyment of life</u> during the past week:

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

How has your pain interfered with your <u>general activity</u> during the past week:

Does Not Interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

What makes your pain worse? (Check all that apply)

- ☐ Bending
- ☐ Housework
- ☐ Lifting
- ☐ Lying down
- ☐ Movement
- ☐ Prolonged Positioning
- ☐ Running
- ☐ Sitting
- ☐ Stairs
- ☐ Standing
- ☐ Twisting
- ☐ Walking

Other:_____

What makes your pain better? (Check all that apply)

- ☐ Changing positions
- ☐ Chiropractic
- ☐ Heat
- ☐ Ice
- ☐ Lying down
- ☐ Massage
- ☐ Medications
- ☐ Physical Therapy
- ☐ Rest
- ☐ Sitting
- ☐ Standing
- ☐ Stretching
- ☐ TENS Unit
- ☐ Walking

Other:_____

Since I was last seen, I have had the following symptoms:

- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Leg swelling
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Loss of bladder contr
- ☐ Cold intolerant
- ☐ Heat intolerant
- ☐ Anxiety
- ☐ Vomiting
- ☐ Headache
- ☐ Depression
- ☐ Trouble Sleeping

Other concerns I have today: _____

I have had a change in my work status, marital status or smoking status:_____

Are you taking any medications that contain acetaminophen (Tylenol): ☐ Yes ☐ No

My primary Doctor/Facility is:_____

Depression Screen

Patient Health Questionnaire (PHQ-9)

Name:_____ **Date:**_____

Over the last two weeks, how often have you been bothered by any of the following problems?

(PLEASE CHECK YOUR ANSWER)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	①	②	③	④
2. Feeling down, depressed, or hopeless	①	②	③	④
3. Trouble falling or staying asleep, or sleeping too much	①	②	③	④
4. Feeling tired or having little energy	①	②	③	④
5. Poor appetite or overeating	①	②	③	④
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	①	②	③	④
7. Trouble concentrating on things, such as reading the newspaper or watching television	①	②	③	④
8. Moving or speaking so slowly that other people could have noticed. Or the opposite–being so fidgety or restless that you have been moving around a lot more than usual	①	②	③	④
9. Thoughts that you would be better off dead, or of hurting yourself	①	②	③	④
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	◯ Not difficult at all	◯ Somewhat difficult	◯ Very difficult	◯ Extremely Difficult