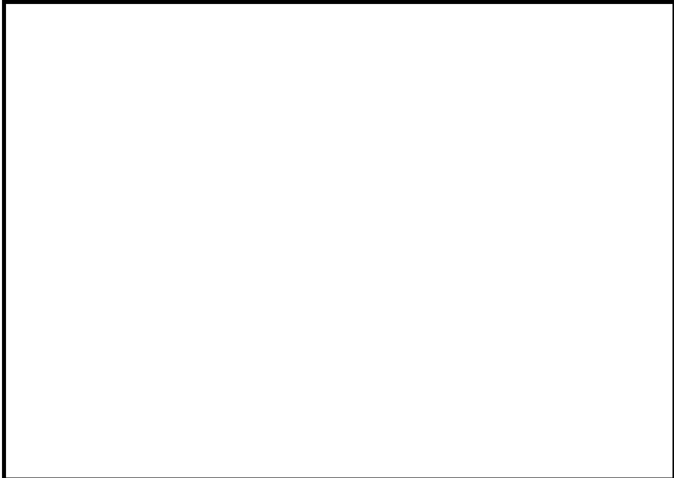
SUMNER PAIN CLINIC
HIGHPOINT HEALTH PARTNERS



Return Patient Intake – Female

Name: ______________________________
Date of Birth: _______________ Age: ______

Pain Location:

R L L R L R

Shade areas where
you have pain.
Then label with letters
that best describe
your symptoms:
A=Aching
B=Burning
D=Deep
G=Gnawing
N=Numbness
P=Pressure
S=Stabbing
T=Throbbing

Pain Description

Since last seen, your pain has: ☐ Increased ☐ Decreased ☐ Remained the same
What best describes your pain? ☐ Constant ☐ Intermittent
When is your pain worst? ☐ Morning ☐ Daytime ☐ Evening ☐ Night
What makes your pain better? ____________________
What makes your pain worse? ____________________

Pain Score

Pain score now:	0 1 2 3 4 5 6 7 8 9 10
Average pain score, last 24 hours:	0 1 2 3 4 5 6 7 8 9 10
Average pain score, last 3 months:	0 1 2 3 4 5 6 7 8 9 10
How many times per day (24-hour period) do you need to take medication for pain?	0 1 2 3 4 5 6 7 8 9 10

In the past three months, have you developed any of the following?
☐ Balance problems ☐ Difficulty walking ☐ New numbness
☐ Bladder incontinence ☐ Bowel incontinence ☐ New weakness

Please indicate if you suffer from any of the following symptoms:

Constitution	**Eyes**	**Gastrointestinal**	**Hematology**
☐ Fever/chills ☐ Weight loss ☐ Malaise/fatigue ☐ Weakness	☐ Blurred/changes to vision ☐ Sensitivity to light ☐ Eye pain ☐ Eye discharge	☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Incontinence of stool	☐ Easy bruising ☐ Easy bleeding ☐ Blood clots
Skin	**Cardiovascular**	**Genitourinary**	**Neurological**
☐ Rash ☐ Itching	☐ Chest pain ☐ Palpitations ☐ Ankle/leg swelling ☐ Difficulty breathing when lying flat	☐ Painful urination ☐ Blood in urine ☐ Flank pain ☐ Incontinence of urine	☐ Dizziness/ lightheadedness ☐ Headaches ☐ Tingling ☐ Tremor ☐ Sensory change ☐ Focal weakness ☐ Seizures
Ears/Nose/Throat	**Respiratory**	**Musculoskeletal**	**Psychiatric**
☐ Hearing loss ☐ Ear pain ☐ Nose bleeds ☐ Sinus pain ☐ Sore throat ☐ Dry mouth	☐ Cough/cold ☐ Sputum production ☐ Shortness of breath ☐ Wheezing	☐ Muscle pains ☐ Neck pain ☐ Back pain ☐ Joint pain ☐ Recent falls ☐ Loss of height	☐ Depression ☐ Suicidal thoughts ☐ Hallucinations ☐ Anxiety ☐ Difficulty sleeping ☐ Memory loss

Other: ____________________

Signature: ____________________ Date: ____________ Time: _______