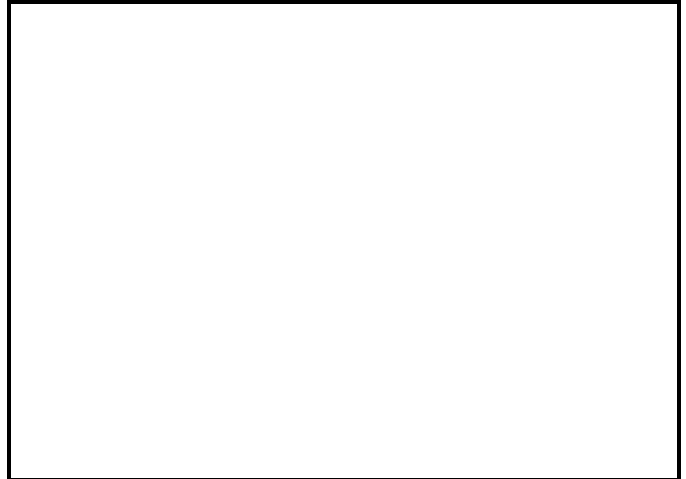


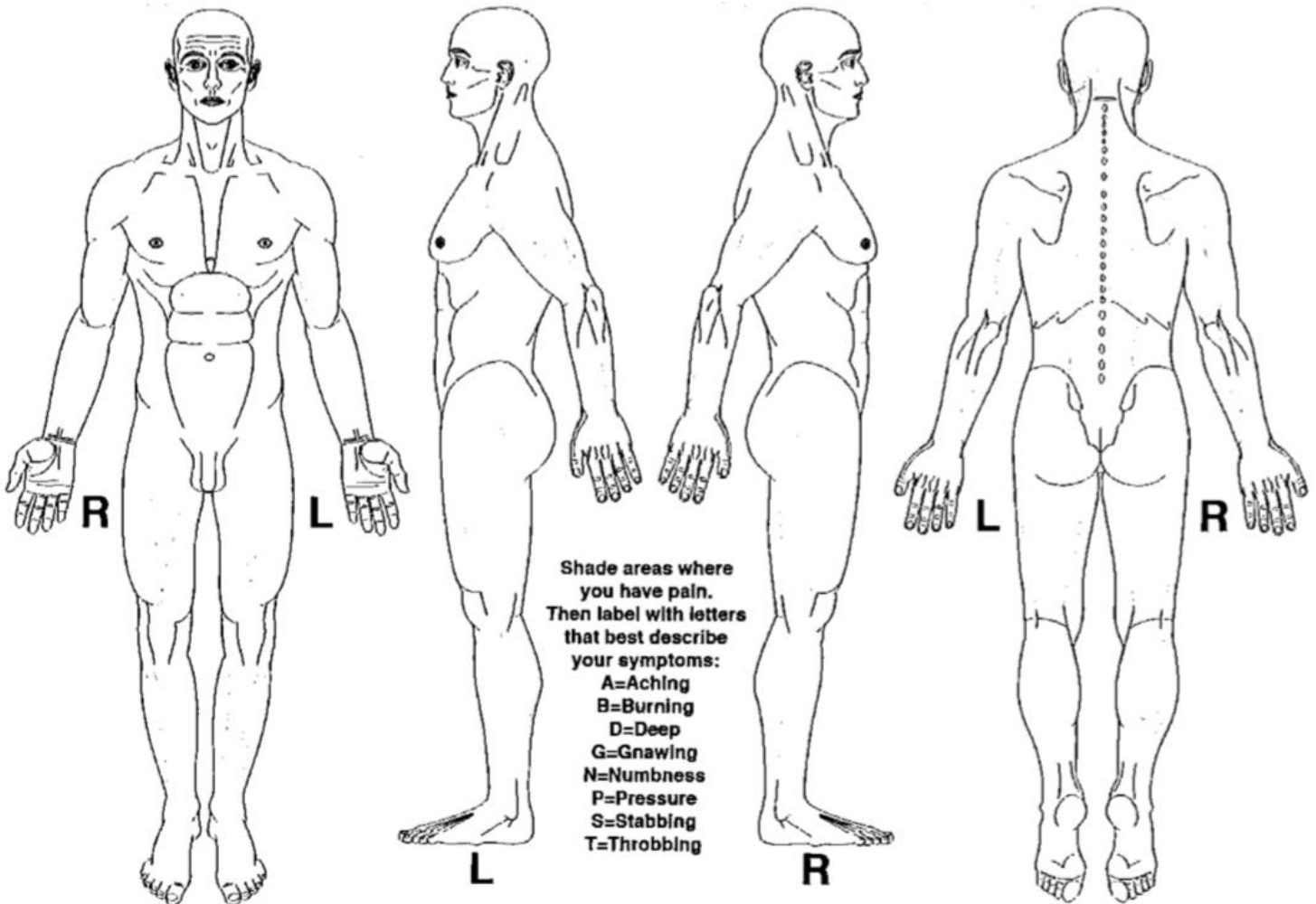
Return Patient Intake – Male

Name: _____

Date of Birth: _____ Age: _____



Pain Location:



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
 If so, which medication(s): _____

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

Other: _____

Signature: _____ Date: _____ Time: _____