



Appt Time: _____

Check- In Time: _____

Which doctor are you here to see?

Dr. Allen W. Burton

Dr. Phillip C. Phan

NEW PATIENT

Date of visit: _____

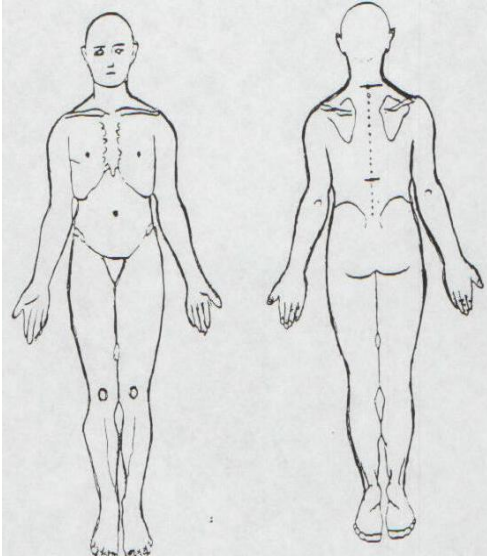
Patient: _____ Date of birth: _____

Pain/Chief Complaint: _____

How long have you had this pain? _____

Has the pain recently changed in intensity and/or character? YES or NO If YES, describe: _____

Where is it located: (shade diagram, mark worst spot with an X)



PAIN SCALE	
Over the last week, rate:	
	None Worst
Worst Pain:	0 1 2 3 4 5 6 7 8 9 10
Least Pain:	0 1 2 3 4 5 6 7 8 9 10
Usually:	0 1 2 3 4 5 6 7 8 9 10
Right Now:	0 1 2 3 4 5 6 7 8 9 10
Acceptable Level:	0 1 2 3 4 5 6 7 8 9 10

Office use only:	
Vital Signs	
Temp:	_____
Pulse:	_____
Resp:	_____
BP:	_____
Wt:	_____

What makes the pain better? (Circle all that apply)

Heat Cold Walking Sitting Standing Massage Resting in bed Medications Other: _____

What makes the pain worse? (Circle all that apply)

Heat Cold Walking Sitting Standing Activity Bending down Stretching Running Coughing Being still Lying down Other: _____

How would you describe your pain? (Circle all that apply)

Aching Penetrating Stabbing Tender Miserable Twisting Tiring Shooting Numb Sharp Burning Pressure Throbbing Nagging Gnawing Unbearable Dull Tingling Shocking Other: _____

CURRENT MEDICATIONS:

Medications	Dose	Frequency

ALLERGY: _____ Reaction: _____ Other Pain Treatments: (Circle all that apply) Physical Therapy TENS Unit Nerve Blocks Other: _____ How much pain relief have pain treatments and medicines (in total) provided for you in this past week? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
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Does your pain interfere with your: (Circle all that apply)

General Activity Normal Work Relationships Mood Sleep Life Enjoyment

What other symptoms do you have: (Circle all that apply)

Fatigue Nausea Depression Anxiety Drowsiness Difficulty Thinking Shortness of Breath
Poor Appetite Insomnia Feeling of Well-Being

Bowel Patterns:

Usual Frequency: _____ Last BM: _____ Bowel Regimen: YES or NO

Sexual Dysfunction: YES or NO

Past Medical History: (Circle all that apply)

Diabetes High Blood Pressure Seizure Stroke Heart Attacks
Kidney Problems Liver Problems Bleeding Problems Cancer Infections

Other: _____

Past Surgery History: (Past surgeries with dates)

Family History of Cancer or Painful Conditions:

Social History

Marital Status: Married Single Separated Divorced

Children (#): _____ **Occupation:** _____

Smoking: YES or NO or Quit **Pack per day:** _____ **How long have you smoked?** _____

Alcohol Use: Never Occasionally Frequently **Drinks per day:** _____

History of Drug Abuse: YES or NO If yes, please elaborate: _____

Anything we can help you with today? _____
