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Name:	**Age:**	**Date:**

1. Since my last visit, my symptoms are (please check one):

☐ Unchanged	☐ Improved. Describe: _____	☐ Worsened. Describe: _____

2. Since we last saw you have you:

Had any new problems? ☐Y ☐N **If yes,** describe:

Seen any other physicians? ☐Y ☐N **If yes,** describe:

Had any other treatments? ☐Y ☐N **If yes,** describe:

Had any diagnostic tests? ☐Y ☐N **If yes,** describe:

Had a change in your physical limitations? ☐Y ☐N **If yes,** describe:

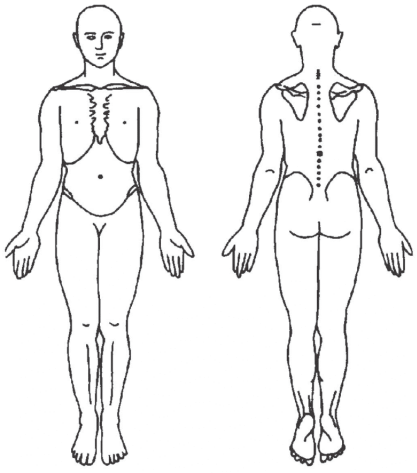
Had a change in your work status? ☐Y ☐N **If yes,** describe:

3. Provide the following for all the **medications that are being prescribed to treat your pain:**

Medication	**Dosage/Frequency**	**Prescribed By**	**Medication**	**Dosage/Frequency**	**Prescribed By**
1.			4.		
2.			5.		
3.			6.		

4. Please mark the location(s) of your pain on the body outlines using the symbols below.

===== Pins & Needles	XXXX Numbness XXXX	ZZZZZ Stabbing ZZZZZ	/// /// /// Aching & /// /// /// Cramping	BBBB Burning BBBB Sensation



Place a mark on the line that represents your level of pain TODAY

|------|------|------|------|------|------|------|------|------|------|
1 **10**

Place a mark on the line that represents your level of pain IN THE LAST WEEK

|------|------|------|------|------|------|------|------|------|------|
1 **10**