Patient Name: _____ DATE: _____

Birthdate: _____ SEX: M / F Height: _____ Weight: _____ Blood Pressure:_____

Are you currently being treated for hypertension by another MD? YES or NO

Referring Physician: _____ Phone: _____

Have you had any falls in the past year? Yes____ No____ Date(s) you fell:_____

History of Current Illness/Episode:

Description of Current Problem/Chief Complaints:

_____

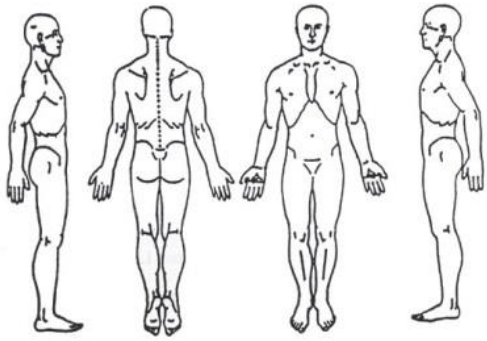
_____

_____

Any history of similar complaint? Yes ___ No ___ When? _____

What was the cause of current problem? _____

Mark on picture the location of your Pain



Date this episode started? _____ Are you improving? ____ Getting worse? ____ Staying the same?____

How do you feel TODAY? I _____I

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

Have you experienced any: (Circle) Burning / Dull Ache / Sharp Stabbing / Throbbing / Numbness / Pins & Needles / Spasm / Swelling / Stiffness Location:_____

How often are your symptoms present?

(Occasional) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., household chores, social activities, work)? I _____I

0 1 2 3 4 5 6 7 8 9 10

No Interference Complete Interference

Name the activities that increase your symptoms: _____

What relieves your symptoms? _____

What treatments including medications have you tried for these symptoms?

_____