Medicus Pain and Spine, PLC
Personalized Pain Care

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Temp: _____ Pain: _____

Return Patient Assessment Form

Name: _____ Age: _____ Visit Date: _____

How has your pain changed since your last visit?

☐ Decreased ☐ Increased ☐ No change

Where is your pain located today?

_____

DESCRIBE THE QUALITY OF YOUR PAIN BELOW:

My pain feels like it is (circle those that apply)

Throbbing	Stabbing	Cramping	Hot-Burning	Dull
Shooting	Sharp	Gnawing	Aching	

DESCRIBE THE INTENSITY OF YOUR PAIN BELOW:

1. Describe your pain at its **WORST**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

2. Describe your pain at its **BEST**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

3. Describe your pain on **AVERAGE**:
   0 1 2 3 4 5 6 7 8 9 10
   No Pain Worst Pain Imaginable

4. What makes the pain worse? Circle all that apply.

bending forward	defecating	walking	running
bending back	coughing	lying down	sexual intercourse
lifting	sneezing	prolonged standing	stress
urinating	changing position	prolonged sitting	

If the above do not apply, please describe what makes your pain worse:

_____

5. What makes the pain better? Circle all that apply.

Heat	Medication	Standing	Lying down	Resting
Ice	Walking	Sitting	Changing position	

If the above do not apply, please describe what makes your pain better:

_____

6. Are there other symptoms associated with the pain? Circle all that apply.

Difficulty sleeping Depression Loss of appetite Fever Weakness

CURRENT MEDICATIONS □ **NO CHANGE since last visit**

Name	Dosage	How Often?

DRUG ALLERGIES: □ NO CHANGE since last visit □ CHANGE since last visit

PAST MEDICAL HISTORY: □ NO CHANGE since last visit □ CHANGE since last visit

PAST SURGICAL HISTORY: □ NO CHANGE since last visit □ CHANGE since last visit

FAMILY HISTORY: □ NO CHANGE since last visit □ CHANGE since last visit

SOCIAL HISTORY: □ NO CHANGE since last visit □ CHANGE since last visit

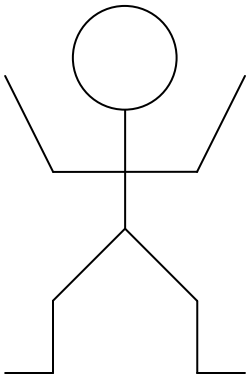
1. Do you currently smoke? □ No □ Yes, _____packs/day for _____years
2. Do you currently use alcohol? □ No □ Yes _____drinks/day
3. Do you currently use recreational drugs? □ No □ Yes, type_____
4. Have you been exposed to toxic/poisonous substances at work or home? □ No □ Yes

REVIEW OF SYSTEMS

Please circle your current symptoms under each heading, if none circle No Problems

Constitutional	fever	weight loss	fatigue
No problems	loss of appetite	weight gain	night sweats
Cardiovascular	chest pain	palpitations	fainting spells
No problems	leg swelling		
Respiratory	trouble breathing	chronic cough	coughing blood
No problems	shortness of breath		
Gastrointestinal	nausea/vomiting	heart burn	loss of bowel control
No problems	diarrhea	constipation	blood in stool
Genitourinary	loss of bladder control	pain on urination	blood in urine
No problems			
Musculoskeletal	muscle cramps	joint pain	joint swelling
No problems	loss of muscle bulk	muscle twitches	
Dermatologic	rash	nail changes	sweating changes
No problems	hives	skin discoloration	itching
Neurologic	headaches	memory loss	seizures
No problems	weakness	tremors	
Psychiatric	hallucinations	high stress levels	inappropriate crying
No problems	suicidal thoughts		
Hematologic/Lymphatic	abnormal bleeding	abnormal bruising	swollen glands
No problems			

PLEASE DO NOT WRITE BELOW THIS LINE



Neck: nl_____

_____

Lungs: nl_____

Heart: nl_____

Mscsktl: nl_____

_____

_____

_____

Back/Pelvis: nl

Palpation: nl_____

_____

Sacroiliac: nl_____

_____

ROM: flex nl _____

ext nl _____

Neurologic: nl

T: R + - L + - H: R + - L + -

Strength: nl_____

Sensation: nl_____

Other: _____

_____