DESERT SKY
SPINE & SPORTS MEDICINE

Name ____________________________ Date of birth _____/____/______ Today's date ____/____/_______

Problem/reason for your visit today ____

Since your last visit here, have you had any of the following:

1. Treatment: (circle) Physical therapy Steroid injections Exercise Surgery Testing

   Medications: (list) ______________________________ Other: ___________

2. List any new medical problems: None Yes If yes, please describe: ______________________

3. Any new allergies: No Yes If yes, please explain: ______________________

4. Any new medications: No Yes If yes, please list: ______________________

5. Any changes in your health, family, social situation: No Yes If yes, please explain: ______________________

6. Any changes in your condition / pain (circle) Better No change Worse

   Describe changes: ______________________________

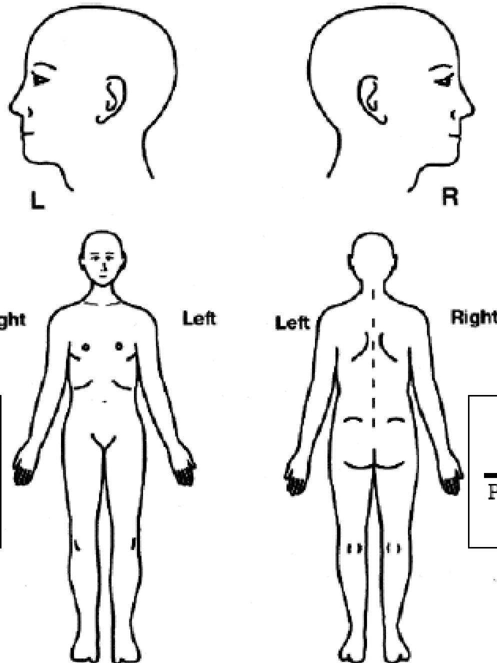
7. Please rate the severity of your condition (circle the number):

   Circle your **current pain** on the graph ______________________________
   0 1 2 3 4 5 6 7 8 9 10
   No pain Severe pain

   Circle your **worst pain** on the graph ______________________________
   0 1 2 3 4 5 6 7 8 9 10
   No pain Severe pain

   Circle your **least pain** on the graph ______________________________
   0 1 2 3 4 5 6 7 8 9 10
   No pain Severe pain

8. Draw your pain on the diagram shown. Use corresponding symbols to show the type of pain you feel.



Stabbing pain /////
Burning pain 000
Aching pain xxxx
Numbness = = = =
Pins & needles v v v

____
Patient's signature

____
Physician/Examiner's signature