Print Form

Patient Name: _____ Date: _____

Medication List – Please include OTC and Supplements
*You may skip this section if you submitted a prepared Medication List

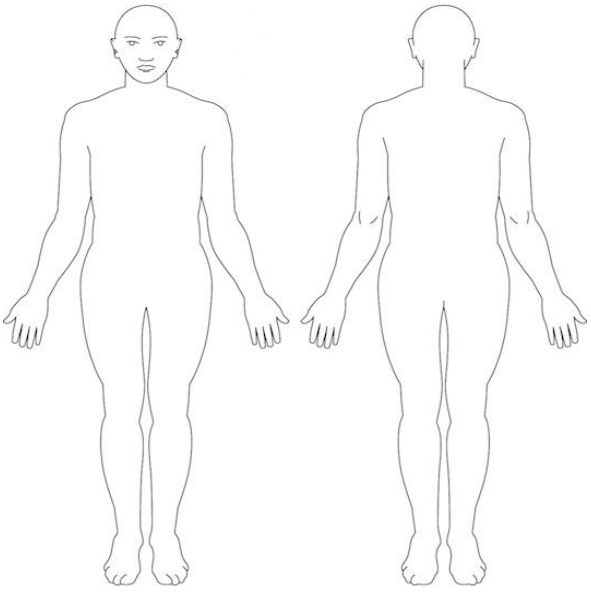
Drug Name	Dosage	Frequency	Route

Pain Scale: Where would you rank your pain?

0	1	2	3	4	5	6	7	8	9	10
☐ No Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Worse Pain

Please draw in your primary complain using the diagram and the markings (also draw other pain areas that you may have at this time)

Ache	Burning	Numbness	Pins and Needles	Throbbing	Other/General Pain
^ ^ ^ ^	= = = = =	oooooooo	……	///////////////	xxxxxxxxxxxxxx
^ ^ ^ ^	= = = = =	oooooooo	……	///////////////	xxxxxxxxxxxxxx



My goal for therapy is: _____

_____

_____

Patient's Signature: _____

This form is completed by the patient