

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Medication List** – Please include OTC and Supplements

\*You may skip this section if you submitted a prepared Medication List

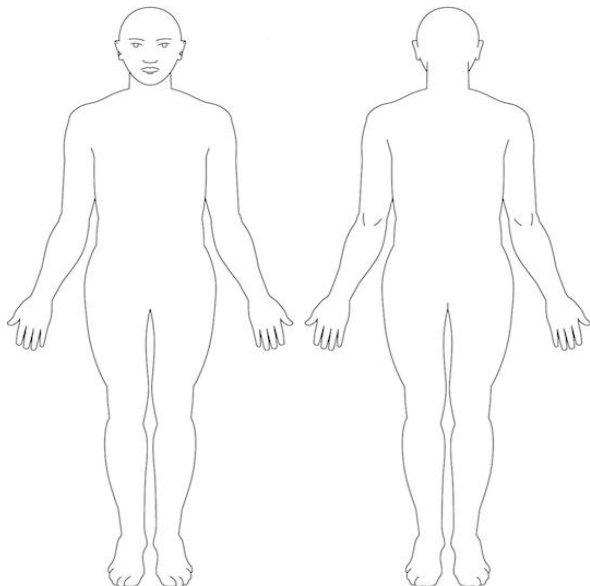
<u>Drug Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Route</u>

**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)

<u>Ache</u>	<u>Burning</u>	<u>Numbness</u>	<u>Pins and Needles</u>	<u>Throbbing</u>	<u>Other/General Pain</u>
^ ^ ^ ^	=====	oooooooo	.....	//////////	xxxxxxxxxxxxxx
^ ^ ^ ^	=====	oooooooo	.....	//////////	xxxxxxxxxxxxxx



My goal for therapy is: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_

This form is completed by the patient