NEUROLOGY AND SPINE CENTER

VISIT INFORMATION

Name: _____ **Date:** _____

Email (For Patient Portal):_____

Reason for Visit/ General Concerns:

_____

_____

_____

_____

_____

_____

Medical/medication changes since last visit:

_____

_____

_____

_____

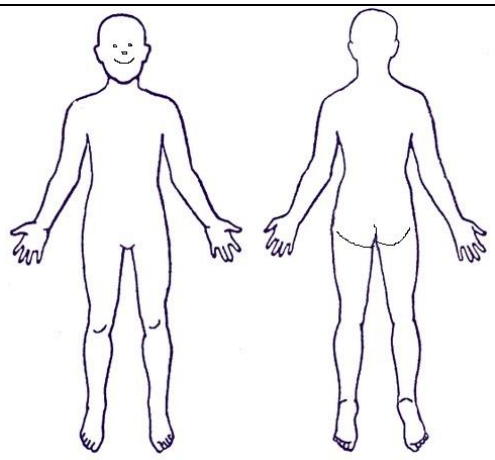
_____

_____

PAIN PATIENTS: Complete the following assessment EACH visit

Describe your pain: CHECK ALL THAT APPLY

QUALITY		WORSENED BY		RELIEVED BY	
Sharp		Sitting		Lying Down	
Stabbing		Movement		Upright Position	
Aching		Cough/Deep Pressure		Lying on Side R/L	
Throbbing		Activity		Heat	
Burning		Cold		Ice	
Radiating		Barometric Pressure		Rest	
Dull		Stress		Medications	
Tingling		Work		Therapy	
Constant		Sleep		Exercise	
Intermittent		Physical Exertion		Injections	
Other		Nothing		Nothing	
Other		Other		Other	



Front Back

Pain Range: _____

0 1 2 3 4 5 6 7 8 9 10

New Patients: What's the lowest it ever gets and the highest it ever gets since onset

Follow up patients: Lowest and highest since the last office visit