

For Acute, Chronic & Cancer Pain

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In order for us to obtain a complete medical	al history, it is import	tant for you t	to fill out this form as completely as possible	
This is very important information. Please fil	Il out every item. It is	s important tred into the o		
	the report if yo	ou wisii.		
Full Name	Male	Female	_ Date of Birth	
( <u>Current Medica</u> (Please include p	tions) Are you taking rescription, over-the	g ANY kind o	of medication now? herbal medications)	
Medication Name	<u>Dosage</u>	How ofter		
(Medication Allergies)ARE	OU ALLERGIC TO	ANY MEDIC	CATIONS? Yes No	
Name of Medication		Type of Reaction (Rash, Swelling, etc.)		
Past Surgical H	listory if no surgica	al history ch	eck none	
Type of Surgery or Procedure			Date of Surgery or Procedure	
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Full Name	Date of Birth	
Preferred Pharmacy/Location		
What is the main reason you are here today?		
Is this a Worker's Comp injury? Date:/ Explain inju	ury:	
How long has pain/symptom been present?Hours	DaysMonthsYears	
Please circle the type of pain you are having: AchingBurning	Stabbing Sharp Other	
What would you rate your pain today? Please circle: Lowest pain	1 2 3 4 5 6 7 8 9 10 <i>Highest pain</i>	
Have you done any Physical Therapy? yes or no Where?	how many sessions	
Have you tried any Injections? yes or no Where?	how many?	
R L R R L	Please mark the body locations where you are having pain.	
Patient Signature	Date	