

**Return Patient Intake – Female**

Name:

Date of Birth: Age:

Pain Location:



**Pain Description**

Since last seen, your pain has: ⬜ Increased ⬜ Decreased ⬜ Remained the same

What best describes your pain? ⬜ Constant ⬜ Intermittent

When is your pain worst? ⬜ Morning ⬜ Daytime ⬜ Evening ⬜ Night

What makes your pain better?

What makes your pain worse?

**Pain Score**

Pain score now: 0 1 2 3 4 5 6 7 8 9 10

Average pain score, last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Average pain score, last 3 months: 0 1 2 3 4 5 6 7 8 9 10

How many times per day (24-hour period)

 do you need to take medication for pain? 0 1 2 3 4 5 6 7 8 9 10

In the past three months, have you developed any of the following?

⬜ Balance problems ⬜ Difficulty walking ⬜ New numbness

⬜ Bladder incontinence ⬜ Bowel incontinence ⬜ New weakness

**Please indicate if you suffer from any of the following symptoms:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Constitution**⬜ Fever/chills⬜ Weight loss⬜ Malaise/fatigue⬜ Weakness | **Eyes**⬜ Blurred/changes to vision⬜ Sensitivity to light⬜ Eye pain⬜ Eye discharge | **Gastrointestinal**⬜ Heartburn⬜ Nausea⬜ Vomiting⬜ Abdominal pain⬜ Diarrhea⬜ Constipation⬜ Incontinence of stool | **Hematology**⬜ Easy bruising⬜ Easy bleeding⬜ Blood clots |
| **Skin**⬜ Rash⬜ Itching | **Cardiovascular**⬜ Chest pain⬜ Palpitations⬜ Ankle/leg swelling⬜ Difficulty breathing when lying flat | **Genitourinary**⬜ Painful urination⬜ Blood in urine⬜ Flank pain⬜ Incontinence of urine | **Neurological**⬜ Dizziness/ lightheadedness⬜ Headaches⬜ Tingling⬜ Tremor⬜ Sensory change⬜ Focal weakness⬜ Seizures |
| **Ears/Nose/Throat**⬜ Hearing loss⬜ Ear pain⬜ Nose bleeds⬜ Sinus pain⬜ Sore throat⬜ Dry mouth | **Respiratory**⬜ Cough/cold⬜ Sputum production⬜ Shortness of breath⬜ Wheezing | **Musculoskeletal**⬜ Muscle pains⬜ Neck pain⬜ Back pain⬜ Joint pain⬜ Recent falls⬜ Loss of height | **Psychiatric**⬜ Depression⬜ Suicidal thoughts⬜ Hallucinations⬜ Anxiety⬜ Difficulty sleeping⬜ Memory loss |

Other:

Signature: Date: Time: