MD PAIN Review of Systems

Name: _____ **Today's Date:** _____ **Age:** _____ **Height :** _____ **Weight:** _____
Gender (circle) : Male Female Transgender

Reason for Today's Visit (Mark ALL that apply)

☐Routine follow up	☐Medication problem or change
☐Imaging review	☐Post-procedural assessment
☐Medication refill	☐New problem: _____
☐Test result review	☐Other: _____

My CHIEF PAIN COMPLAINT is: (Mark only ONE)

☐headache	☐neck pain	☐left arm pain
☐facial pain	☐mid-back pain	☐right arm pain
☐chest wall pain	☐low-back pain	☐left leg pain
☐abdominal pain	☐buttock pain	☐right leg pain
☐groin pain	☐tailbone pain	☐other: _____

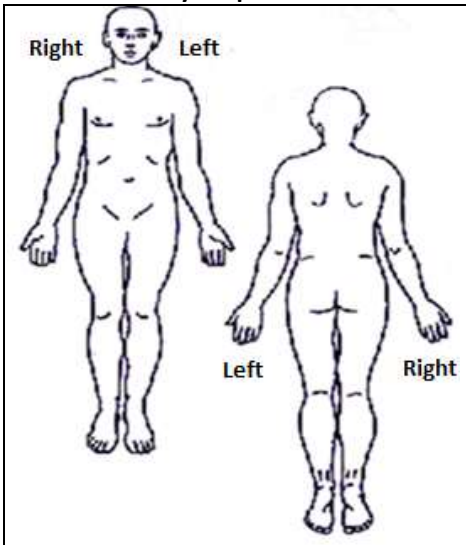
My ADDITIONAL pain complaint(s) is (are): (Mark ALL that apply)

☐headache	☐neck pain	☐left arm pain
☐facial pain	☐mid-back pain	☐right arm pain
☐chest wall pain	☐low-back pain	☐left leg pain
☐abdominal pain	☐buttock pain	☐right leg pain
☐groin pain	☐tailbone pain	☐other: _____

Pain Description

Severity (0=no pain,10=worst pain)	**Frequency** (Mark only ONE)
Your pain right now: ____/10	☐constant
Your worst pain: ____/10	☐fluctuating, always present
Your least pain: ____/10	☐fluctuating, usually present
Your average pain: ____/10	☐fluctuating, rarely present

Indicate where your pain is located:



1. Use the following letters to describe your pain.
Ache = A
Burning = B
Cramping = C
Dull = D
Numbness = N
Pins/Needles = P
Stabbing = S
Throbbing = T
Muscle spasm = M

2. Draw arrows where the pain radiates.

What makes your pain worse?

What makes your pain better?

Since your last visit at MD Pain, has there been any new:

☐Balance problems	☐Numbness:	☐ Arms ☐ Legs
☐Difficulty walking	☐Tingling:	☐ Arms ☐ Legs
☐Bladder incontinence	☐Weakness:	☐ Arms ☐ Legs
☐Bowel incontinence	☐Other:_____	

Since being treated at MD Pain, how have the following changed:

Pain control	☐Improved	☐Unchanged	☐Worse
Function	☐Improved	☐Unchanged	☐Worse
Quality of life	☐Improved	☐Unchanged	☐Worse

Please list any changes in your current medication regimen:

-Are your pain medications helping? ☐Yes ☐No
-Improved Pain Relief: _____% (0-100%)
-Functional Improvement: _____% (0-100%)
-Improved Quality of Life: _____% (0-100%)
-Are there any side effects? ☐Yes ☐No
-If 'Yes', which?
Since your last visit, have you had pain injections? ☐Yes☐No
If 'Yes', which?
If you had an injection, how much relief did it provide? ☐N/A
Decreased pain _____%; Improved function _____% (0-100 %)
What was the duration of relief? _____
Alcohol Use: ☐ Yes, infrequently ☐ Yes, daily ☐ No/Never
☐ History of alcoholism
Prescription medication or illegal drug misuse/abuse or addiction: ☐ Yes, currently ☐ Yes, in the past ☐ Never
Are you receiving other treatments for your pain? ☐Yes ☐No

-Physical therapy:	☐Helpful	☐Not Helpful	☐N/A
-Chiropractic:	☐Helpful	☐Not Helpful	☐N/A
-Massage/Acupuncture:	☐Helpful	☐Not Helpful	☐N/A
-TENS Therapy:	☐Helpful	☐Not Helpful	☐N/A
-Bracing/Orthotics:	☐Helpful	☐Not Helpful	☐N/A
-Other: _____	☐Helpful	☐Not Helpful	☐N/A

Since your last visit, any new testing/images? ☐Yes ☐No
If 'Yes', which?
Since your last visit, any new medications? ☐Yes ☐No
If 'Yes', which?
Since your last visit, any changes in your health? ☐Yes ☐No
If 'Yes', which?
Since your last visit, any hospitalizations/surgery? ☐Yes☐No
If 'Yes', explain?
Since your last visit, any new blood thinners? ☐Yes ☐No
If 'Yes', which?
Since your last visit, other problems/concerns? ☐Yes ☐No
If 'Yes', which?

Additional Information

Please list any additional information in the space below:

I certify that the above information is accurate and true.

Date: _____

Signed: _____