Print in Color or Grayscale OnlyUsing Adobe Acrobat Reader 8.0 or later

Established Patient

Please answer every question.

STAFF: Responses in boxes
and handwritten items must
be entered MANUALLY .

		PLEASE PR	INT PATIENT'S LAST I	NAIVIE		
Marking Instruct	tions	,				
			INT PATIENT'S FIRST	T PATIENT'S FIRST NAME PATIENT'S DATE C		
Fill in the complete oval as shown						
Thirtie complete oval as shown					Month Day	Year
How did you arrive today?	wheelchair	\bigcirc	crutches 🔾	cane 🔾	walker 🔾	no assistance
Are you currently employed?				15.	yes 🔾	no
Who is with you today?				self 🔘	male 🔾	female
Has anything changed since you					yes 🔾	no
If "yes", mark all that	• • •					
accident 🔾	family		illness	\bigcirc	surgery O	treatment
Have you had a change in medic					yes 🔾	no
Are you being treated for hyper	tension (high b	lood press	ure)?		yes 🔾	no
If female, are you pregnant?	no 🔘	yes	O m	aybe 🔘	Due date: _	
What is your smoking status?	current (every	day)	current (so	ome days)	previous	never
How many packs of cigarettes d	o you (or did y	ou) smoke	daily?			
<½	1/2	3/4	<u> </u>	1 1/2	2	>2
If you smoke (or did smoke), ho						
many years have you smoked?			10 20	10 20	30 40 50	60 70 80
many years have you smokeu!	Exa	ample:			\circ	
(If you smoked intermittently, ac	dd 21	is marked	1 2	1 2	3 4 5	6 7 8
the years that you smoked.)					\circ	$\circ \circ \circ$
· · · · · · · · · · · · · · · · · · ·						
If you smoked previously, when	did you stop s		-			
	<2 🔾	2-6	\bigcirc	6-12 🔵	12-24	>24
Location of pain?	right side		left side	\bigcirc	both sides 🔘	midline
Type of pain?	J					
	pain 🔘	abdomi	nal / pelvic pain		back pain 🔘	other
Current status of problem:			resolved 🔘		no change 🔘	changed
Current pain you are having (mo	ark all that appl	ly):	crushing 🔘	pres	ssure O	sore
aching			gnawing 🔘		harp 🔘	stabbing
burning		nd needles	sensation	shocl	k-like 🔘	throbbing
Severity compared to last visit:	<u> </u>		oved 🔘	more severe		no change
Pain score on scale from 0-10:	(0 being no pair	n to 10 beii	ng most severe p	ain imaginable)		
No Pain 🙂	0 1 2	3 Д		0 0 10	Most Severe I	Pain Imaginable
No Pain 🙂	0 1 2	-	5 6 7	8 9 10	0	
Functional impairment:		0 4	5 6 7	8 9 10		
			3 0 7		h most but not al	-
Functional impairment:	daily activities	activities	Severe Very S	e: Interferes wit Severe: Unable		l daily activities
Functional impairment: Mild: Doesn't interfere with	daily activities with some daily o	activities redications	Severe Very S	e: Interferes wit Severe: Unable	h most but not al	l daily activities
Functional impairment: Mild: Doesn't interfere with Moderate: Interferes only w Need for pain medication(s): Ability to sleep (as affected by p	daily activities vith some daily o	edications	Severe Very S	e: Interferes wit severe: Unable i ange	h most but not al to carry out any a	l daily activities laily activities
Functional impairment: Mild: Doesn't interfere with Moderate: Interferes only w Need for pain medication(s):	daily activities with some daily on no m vain): same	edications	Severe Very S	e: Interferes wit severe: Unable i ange	h most but not al to carry out any a decreased o	l daily activities laily activities increased
Functional impairment: Mild: Doesn't interfere with Moderate: Interferes only w Need for pain medication(s): Ability to sleep (as affected by p	daily activities vith some daily o no m vain): same	edications	Severe Very S no chaimproved	e: Interferes wit Severe: Unable sange	h most but not al to carry out any a decreased o	Il daily activities laily activities increased not affected
Functional impairment: Mild: Doesn't interfere with Moderate: Interferes only w Need for pain medication(s): Ability to sleep (as affected by p Frequency of problem now:	daily activities vith some daily o no m vain): same	edications unchanged unchanged	Severe Very S no chaimproved	e: Interferes wit evere: Unable a ange w less frequent	h most but not al to carry out any a decreased o	Il daily activities laily activities increased not affected more frequent
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