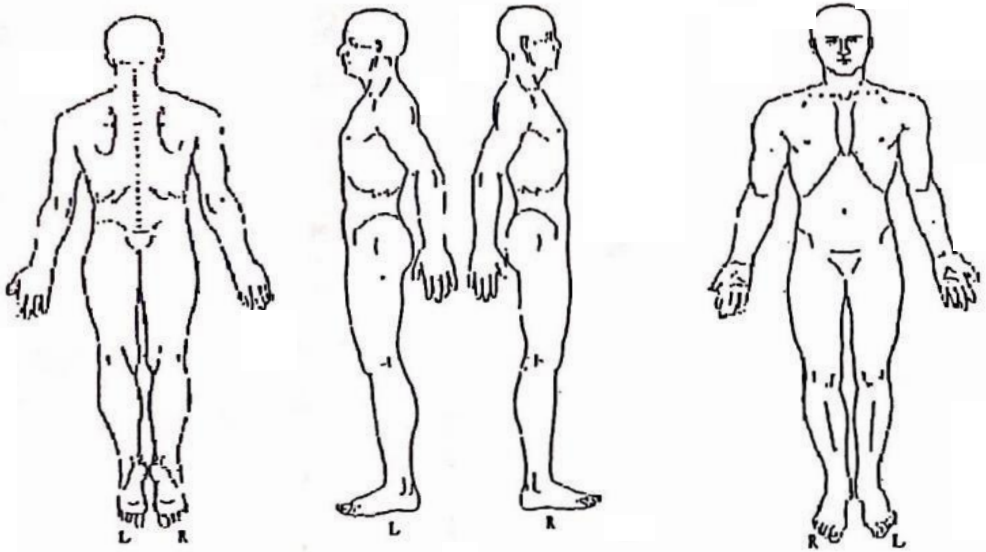
ON THE DIAGRAM BELOW – PLEASE MARK WHERE YOUR PAIN IS LOCATED:



DESCRIBE YOUR PAIN:

- ☐ Aching
- ☐ Burning
- ☐ Discomfort
- ☐ Dull
- ☐ Gnawing
- ☐ Numbness
- ☐ Piercing
- ☐ Sharp
- ☐ Shooting
- ☐ Stabbing
- ☐ Throbbing
- ☐ Tingling

Other: _____

WHAT MAKES YOUR PAIN WORSE:

- ☐ Nothing
- ☐ Stairs
- ☐ Changing Position
- ☐ Daily Activities
- ☐ Jumping
- ☐ Lifting
- ☐ Lying Down/Rest
- ☐ Rolling Over in Bed
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Weather

Other: _____

WHAT MAKES YOUR PAIN BETTER:

- ☐ Nothing
- ☐ Heat
- ☐ Ice
- ☐ Injections
- ☐ Lying Down/Rest
- ☐ Massages
- ☐ Movement
- ☐ Anti-Inflammatory Meds
- ☐ Pain Meds/Drugs
- ☐ Physical Therapy
- ☐ Exercise/Stretching

Other: _____

CURRENT PAIN LEVEL _____ / 10

When did you take your last pain pill? _____

Any procedures since your last visit? ☐ Yes ☐ No **If yes; Relief?** _____%

PLEASE LIST MEDICATIONS YOU NEED REFILLED TODAY: **Pharmacy:** _____

_____

FIRST COAST PAIN

Height:_____ **Weight:**
BP: _____/_____ **T** _____

Patient Follow-Up History / Progress
You must complete this form in its entirety each visit

NAME: _____ **DOB:** _____ **DATE:**_____

How many years/months ago did the main area of pain start? _____

Please **CIRCLE** any symptoms that you have experienced in the last year or since your last visit.

Constitutional:
Chills
Fatigue
Night Sweats
Weight Gain
Weight Loss

HEENT:
Ear Drainage
Ear Pain
Eye Discharge
Eye Pain
Hearing Loss
Nasal Drainage
Sinus Pressure
Sore Throat
Visual Changes

Respiratory:
Cough
Known TB exposure
Shortness of Breath

Cardiovascular:
Chest Pain
Claudication
Edema
Palpitations

Gastrointestinal:
Abdominal Pain
Blood in Stools
Constipation
Diarrhea
Heartburn
Loss of Appetite
Nausea
Vomiting

Genitourinary:
Blood in Urine
Urine Frequency
Urine Incontinence
Urinary Retention

Reproduction:
Erectile Dysfunction
Penile/Vaginal Discharge
Hot Flashes
Irregular Menses
Abnormal Pap

Neurological:
Dizziness
Extremity Numbness
Extremity Weakness
Headaches
Memory Loss
Seizures
Tremors

Integumentary:
Hair Loss
Rashes

Psychiatric:
Anxiety / Depression
Insomnia

Metabolic:
Cold Intolerance
Heat Intolerance
Excessive Thirst
Increased Hunger

Musculoskeletal:
Back Pain
Joint Pain
Joint Swelling
Muscle Weakness
Neck Pain

Hematologic:
Bleed Easily
Bruise Easily
Swollen Lymph Nodes

Immunologic:
Seasonal Allergies
Food Allergies

Have you had any change to your medical history since your last visit? NO YES _____
Have you had any change to your social history since your last visit? NO YES _____
Have you added or changed any medications since your last visit? NO YES _____
Have you had any other changes since your last visit? NO YES _____