1. Location of Pain: ________________________________

2. Duration of Pain:  Hours  Days  Weeks  Months

3. Describe the pain:  Sharp  Dull  Aching

4. Was this the result of an injury?  Yes  No

5. Was the injury work related?  Yes  No

6. What actions or movements cause aggravation to the area?

7. Relieving Factors are:  Ice  Heat  Rest  Medication

8. Wants Injections?  Yes  No

9. Medication Refill?  Yes  No

10. New Patients only, who were you referred by?

   • Dr.  ________________________________

   • Family/Friend:  ________________________________

   • Patient:  ________________________________

Additional Questions?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________