Patient's Name:___________________________________ Date:_____________________________

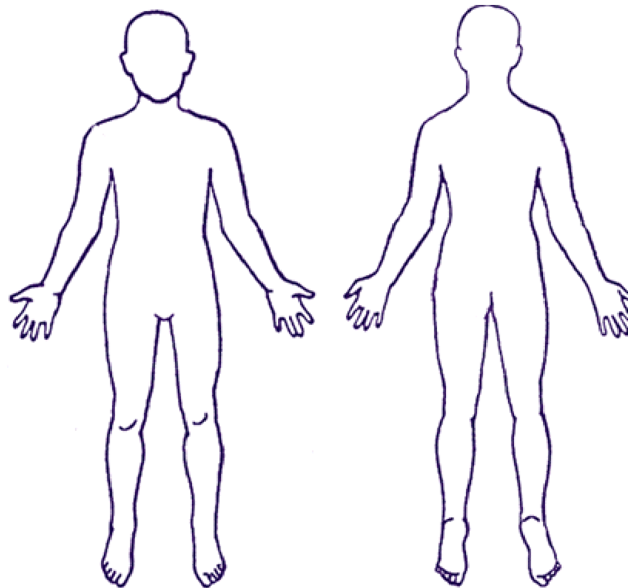
Have you had any changes to your <u>address</u> since your last visit?	YES	NO
Have you had any changes to your phone number since your last visit?	YES	NO
Have you had any changes to your pharmacy since your last visit?	YES	NO
Does your pharmacy have all your medication available?	YES	NO
Have you had any changes to your insurance since your last visit, new insurance, new ID number?	YES	NO

(Office use only) DED/DED MET OOP/OOP MET

Please fill out the pain diagram based on the key where your pain is.

KEY	
//////////////////	STABBING
XXXXXXXXXXX	BURNING
0000000000000	PINS & NEEDLES
------------------	NUMBNESS
+++++++++++++	ACHING

PAIN LEVEL	
0	No pain
1	Mild pain
2	Moderate pain
3	Moderate pain
4-5	More severe pain
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain



Medication Changes by outside physicians

____

____

____

Current pain level: _______ Pain w/o medication: _______ Pain w medication: ________

What activities your pain worse?

____

What activities make your pain better?

____

Please circle the following issues that you have:

Fever Chills Loss of Sleep Loss of Bowel Loss of Bladder Constipation Tremors

Since your last visit have there been any new medical or medication / social issues? Yes or No

If yes please explain

____

What do you want to discuss? Circle ALL that apply:

Medication refill Medication Change Review Labs Review Images New Issue

Other issues:

____

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