Denver Pain Relief Center, PLLC

GENERAL INFORMATION **Today's Date: _____/_____/____**

Patient's Full Name_____ **Date of Birth**_____/_____/_____
(PLEASE PRINT)
Address_____ Care of _____
(Parent or financially responsible person)
City_____ State_____ Zip_____

Phone (work) ____-_____-_____ext.____ Phone (Cell) ____-_____-_____

Emergency Contact Name: _____ Phone: _____

Relationship: _____

What is your MAJOR COMPLAINT(S)?

1._____
2._____
3._____

How long have you had this condition? _____***Date of Onset***_____

Have you missed workdays? YES / NO If yes, how many? _____

Have you had this similar condition before? YES NO If yes, when? _____

Was the injury accident related? YES / NO Auto Accident / Work accident? If yes, when?_____

Primary Care Physician: _____ Clinic Name: _____

PREVIOUS PHYSICAL THERAPY AND/OR CHIROPRACTIC CARE? YES / NO

Clinic Name(s): _____ City/ State: _____

When was your last visit? _____

What was the reason for your initial visit? _____

(please sign the attached Medical Records Release Form)

ANY SURGERIES, HOSPITALIZATIONS, AND SERIOUS ILLNESSES YOU HAVE HAD? (List Year in bracket):

_____

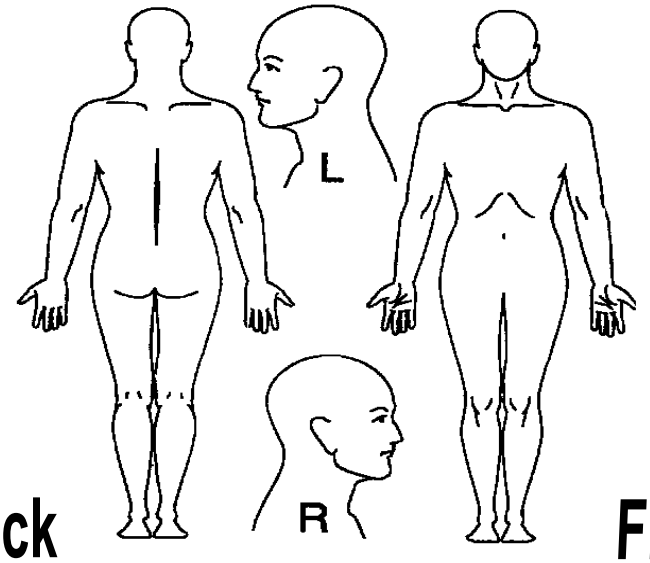
Patient Name: _____ Date: _____

SYMPTOM ASSESSMENT

(To be filled out by the Patient)

MARK ON THIS BODY, USING THE APPROPRIATE SYMBOLS.
PLEASE MARK ALL AREAS USING THE DESCRIBED SENSATIONS
THAT YOU FEEL.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
XXXXXXXX	::::::::::::::::::::	OOOOOO	IIIIIIIIIIIIIIII	++++++++
XXXXXXXX	::::::::::::::::::::	OOOOOO	IIIIIIIIIIIIIIII	++++++++



What is your Pain level RIGHT NOW?

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

What is your TYPICAL or AVERAGE Pain level?

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

What is your Pain level at its BEST (How close to "0" does you pain get at its best?

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

What is your Pain level at its WORST (How close to "10" does your pain get at its worst?

No Pain									Worst Pain
1	2	3	4	5	6	7	8	9	10

Other Comments:

_____

_____

Review of Symptoms: Please check Yes or No for the following **current** symptoms (**within past 3 months**)

GENERAL	Yes	No		**GASTROINTESTINAL**	Yes	No
Fever				Diarrhea/Constipation		
Sweats at night				Indigestion/heartburn		
Hot flashes				Nausea		
Temperature intolerance				Blood in stool		
Excessive thirst				**GENITOURINARY**		
Fatigue				Pain or burning on urination		
Sleep difficulties				Frequent urination		
Daytime sleepiness				Waking to urinate more than once at night		
Unplanned weight change				Excessive urination		
SKIN				Difficulty emptying bladder		
Rash				Urinary incontinence		
New or changing moles				Decreased sexual desire		
EYES				Pain with intercourse		
Pain				Sexually Transmitted Diseases		
Redness				Fertility issues		
Vision change				**Men:**		
EAR, NOSE, THROAT				Erectile dysfunction		
Hearing loss				**Women:**		
Ringing in ears				Heavy vaginal discharge		
Dizziness or vertigo				Heavy menstrual bleeding		
Bleeding gums				Painful menstrual periods		
Nosebleeds				Irregular menstrual bleeding		
BREAST				**MUSCULOSKELETAL**		
Breast Pain				Generalized or all-over pain		
Masses and or Lumps				Joint pain		
Nipple discharge				Stiffness		
Skin changes				Joint swelling		
CARDIOVASCULAR				Joint redness		
Chest pain				Back or neck pain		
Heart murmur				**NEUROLOGICAL**		
Irregular heartbeat (palpitations)				Abnormal gait (Trouble Walking) or falls		
Leg swelling or edema				Headache severe and/or frequent		
PULMONARY				Seizures		
Wheezing or shortness of breath				Muscle weakness, TIA or stroke		
Chronic cough				Fainting or loss of consciousness		
HEMATOPOIETIC				Localized numbness, tingling, neuropathy		
Swollen lymph glands				**PSYCHOLOGICAL**		
Blood clots				Anxiety		
Excessive bleeding				Depression		
Anemia				Memory loss		
				Mood swings		

Do you Drink Alcoholic Beverages? Y / N Average Number of drinks / Week? _____

Do you Smoke? Y / N How many Packs / Day: _____

Do you Drink Coffee? Y / N Cups / Day? _____

Do you Exercise? ____ None ____ Mild ____ Moderate ____ Strenuous

PLEASE LIST ANY KNOWN ALLERGIES:

_____
_____
_____

FAMILY HISTORY:

Does anyone in your family have or had any illnesses/conditions that we should know about? (i.e., Heart Disease, Arthritis, Cancer, etc.)

_____

_____

_____

_____

Patient/ Representative Signature: _____ Date: _____

If not by patient, relationship to patient: _____