NAME:_____
DATE:_____

Crystal Coast Pain Management

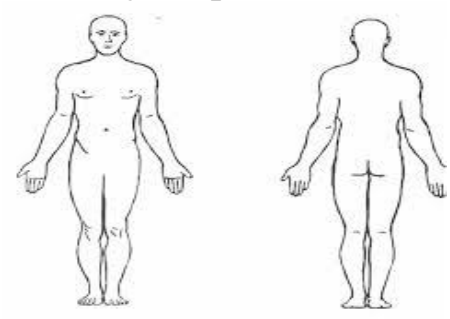
NEW BERN MOREHEAD CITY JACKSONVILLE

Rate your AVERAGE pain

WITHOUT medications:
None- 0 1 2 3 4 5 6 7 8 9 10- worst

WITH medications:
None- 0 1 2 3 4 5 6 7 8 9 10- worst

Shade your painful areas:



What words best describe your pain:

__ Burning __Aching __Sharp
__Constant __Rare __Frequent
__Stabbing __Occasional __Prickling
__Dull __Shooting __Throbbing
__Numbing __Cramping __Stinging
__Electric

What positive changes have you made to improve your pain?

__ Quit/Decreased smoking
__Attempted to lose weight
__Eating healthier
__Became more active/flexible
__Took part in relaxation/mediation
__Volunteered/went back to work

Since you were last seen, have there been any changes in your overall health? If so, Explain:

_____
_____
_____
_____

What medication related side effects have affected you?

__Constipation __Nausea __Dizziness
__Drowsiness __Trouble concentrating
__Sexual problems
__Sleep disturbance

Since you were last seen, have there been any changes in your medications or known allergies? If so, list:

_____
_____
_____
_____

Have you considered hurting yourself or others? __ (Y/N)

Provider Notes: