PPMRC
Physiatric Pain & Medical Rehab Clinic, P.A.

For Office Use Only
Initials ____ Rm. # _____

Name:_____ Today's Date: _____

Reason For Visit:_____ Date Of Birth:_____

Patient Initial / Follow Up

➢ Where is your pain located?

Check: Circle:

☐ Low Back Left Or Right

☐ Mid Back Left Or Right

☐ Neck Left Or Right

☐ Leg Left Or Right

☐ Arm Left Or Right

☐ Other _____

➢ Any new pain? _____

_____

➢ How long have you had this pain?_____

➢ What is your pain level?

0- 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 -10

➢ When is your pain the worst?

Check all that apply:

☐ Morning ☐ Daytime

☐ Evening ☐ Night

➢ Can you describe your pain?

Check all that apply:

☐ Aching ☐ Burning

☐ Constant ☐ Intermittent

☐ Deep ☐ Dull

☐ Improving ☐ Increasing

☐ Numbness ☐ Shooting

☐ Pinching ☐ Pressure

☐ Sharp ☐ Stabbing

☐ Stiffness ☐ Tender

☐ Throbbing ☐ Tingling

☐ On and Off ☐ Localized

☐ Radiation (To:_____)

➢ What makes the pain worse?

_____

_____

➢ What makes the pain better?

_____

_____

➢ Have you experienced any side effects with your medications or therapy?

_____

_____

➢ Any concerns you would like to discuss with Dr.N?

_____

_____

➢ List current medications: (Name, Dosage and Frequency)

_____

_____

_____

_____

_____

_____

➢ Allergies _____

_____

_____

Follow Up Visits

Any changes to your current address or phone number? ☐ Yes ☐ No (If Yes, please fill below)

Address:_____

Home Phone #: _____ Cell Phone # :_____

Any Changes to your insurance information? ☐Yes ☐ No (If Yes, please present card to front desk.)

Insurance Co.: _____ Policy # :_____

Patient Signature: _____

OFFICE USE ONLY:
Reviewed w/Patient ? Yes ☐No _____

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