

Please place a check by any conditions you have experienced since your last appointment:

chills _____	wheezing _____	vomiting _____
night sweats _____	cough _____	abdominal pain _____
fever _____	chest pain _____	unable to control bowel or bladder _____
easy bleeding _____	feet swelling _____	
rash _____	palpitations _____	rushing to urinate _____
bruising _____	nausea _____	frequent urination _____
smell, hearing or _____	diarrhea _____	muscle cramps _____
recent changes in vision, smell, hearing or taste _____		joint pain/swelling _____
shortness of breath _____	indigestion _____	attacks of weakness _____
sputum _____	bloody or dark stools _____	morning stiffness _____
poor appetite _____	convulsions _____	headache _____
numbness/ tingling feet _____	numbness/ tingling hands _____	crying spells _____

Circle the numbers below that best describe how pain has interfered with your daily functioning this past week.

0= Does not interfere

10= Completely interferes

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Relations With Other People	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10

Please have your questions ready for your provider while they are in the room. Once she leaves your room, she will be unavailable to answer questions.

Please notify the staff if you have any changes in your home address, home or cell phone number or insurance card.
