

PATIENT INFORMATION SHEET

Name: _____ **Date:** _____ **Sex:** M / F

Full Address: _____

Home Phone #: _____ **Work Phone #:** _____

Date of Birth: _____ **Age:** _____ **Email:** _____

Have you attended a seminar of Dr. Macdonald's? _____ **Do you have extended health coverage?** _____

Medications: _____

Present Complaint: _____

Pain or problem started on _____

Pains are: Sharp Dull Constant Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with your work? ____ Sleep? ____ Daily Routine? ____ Other? _____

Is condition getting progressively worse? _____

Have you seen any other Doctors or therapists seen for this condition, what did you have done and did it help? _____

Are you taking and medications for this condition? _____

Have you had any surgeries that relate to this condition? _____

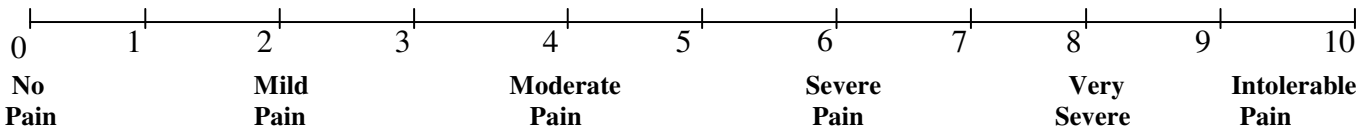
Other Symptoms:

<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Pins and Needles in legs	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	Pins and Needles in Arms	<input type="checkbox"/>	Loss of Smell
<input type="checkbox"/>	Sleeping Problems	<input type="checkbox"/>	Numbness in Fingers	<input type="checkbox"/>	Loss of Taste
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Numbness in Toes	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Feet Cold
<input type="checkbox"/>	Tension	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Hands Cold
<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Stomach Upset
<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	Lights Bothers Eyes	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Loss of Memory	<input type="checkbox"/>	Cold Sweats
<input type="checkbox"/>	Face Flushed	<input type="checkbox"/>	Ears Ring	<input type="checkbox"/>	Loss of Balance
<input type="checkbox"/>	Neck Stiff	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Buzzing in Ears

Patient Pain Assessment

Name: _____
Last
First
Date

0-10 Numeric Pain Intensity Scale (1)



1) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 2 weeks.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Intolerable Pain

2) Please rate your pain by circling the one number that best describes your pain at its **LEAST** in the past 2 weeks.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Intolerable Pain

3) Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Intolerable Pain

4) Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Intolerable Pain

5) What medications and how many are you taking for your pain? _____

6) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely Interferes

B. Walking ability

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely Interferes

C. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely Interferes

D. Sleep

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely Interferes

E. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
 Does not Interfere Completely Interferes