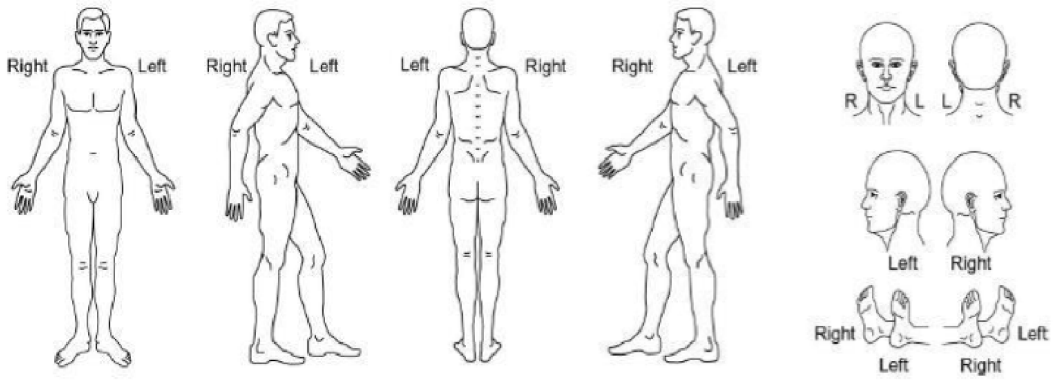
Dr. Vasko Dr. Sikorsky Allison-PA Jincy-PA Rm#_____

Name_____ Date of Birth_____ Today's Date_____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Please describe your pain (circle all that apply): Aching, burning, cramping, crushing, dull, heaviness, electrical, itching, numbness, pulsating, sharp, shooting, stabbing, stinging, throbbing, tightness, tingling, none

Please rate your pain: Currently: ____/10 Best: ____/10 Worst: ____/10 Average: ____/10

What is the duration of your pain? Constant, intermittent, episodic, constant with variable intensity, none

Associated symptoms (circle all that apply): Weakness, numbness, tingling, erectile dysfunction, bladder incontinence, bowel incontinence, stiffness, spasms, loss of motor control, heaviness, interference with sleep, depression, anxiety, none

Aggravating factors (circle all that apply): Any activity, bending, carrying, climbing stairs, changing body position, computer use, driving, exercising, getting out of bed, going from sit to stand, lying down, extension, flexion, lifting, physical therapy, pulling objects, pushing objects, stress, sexual intercourse, sitting, standing, twisting, walking, watching tv, weather changes, none

Alleviating factors (circle all that apply): Acupuncture, bending, chiropractic care, exercise, physical therapy, heat, ice, extension, massage therapy, medication, sitting, standing, stretching, position change, previous procedure, rest, lying down, walking, yoga/Pilates, none

Do you need assistance with Activities of Daily Living? ☐No ☐Yes
Do you take your medications as prescribed? ☐No ☐Yes
Do you feel impaired by your medications? ☐No ☐Yes
Do you drive while impaired? ☐No ☐Yes
Any changes in your medical history since last visit? ☐No ☐Yes If yes,_____
Have you had any surgeries since last visit? ☐No ☐Yes If yes,_____
Any medication changes since your last visit? ☐No ☐Yes If yes,_____
Do you use tobacco? ☐No ☐Former - Year Quit _____ ☐Yes If yes, _____packs/day _____years of use

Please circle any of the following symptoms you are experiencing

Constitutional: Fever, night sweats, weight gain, weight loss, exercise intolerance, none
Respiratory: Cough, wheezing, shortness of breath, coughing up blood, sleep apnea, none
Gastrointestinal: Abdominal pain, vomiting, diarrhea, reflux (GERD), constipation, none
Musculoskeletal: Muscle aches, weakness, arthralgia, joint pain, back pain, swelling in the extremities, none
Neurologic: Depression, sleep disturbances, feeling unsafe in relationship, restless sleep, history of alcohol abuse, none