

Michigan Advanced Pain & Spine, P.C.

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Martin Quiroga, D.O.

Today's date: _____

Date last seen: _____

How would you best describe your pain? (please check all that apply)

Dull, throbbing, aching

Shock-like, numb or tingling

Burning Other

Please Rate your pain by circling the one number that best describes your pain on the average over the past few days. (while taking your medication)

1 2 3 4 5 6 7 8 9 10

What makes your pain worse?

Standing

Walking

Sitting

Bending or twisting

Ice

Hot

What makes your pain better?

Standing

Walking

Sitting

Bending or twisting

Ice

Hot

To what degree has pain interfered with the following activities 1= No interference, 10= Maximum interference.

Your sleep 1...2...3...4...5...6...7...8...9...10

General Activity 1...2...3...4...5...6...7...8...9...10

Mood 1...2...3...4...5...6...7...8...9...10

Walking ability 1...2...3...4...5...6...7...8...9...10

Normal work (at home or outside) 1...2...3...4...5...6...7...8...9...10

Relations with others 1...2...3...4...5...6...7...8...9...10

Enjoyment of life 1...2...3...4...5...6...7...8...9...10

Did your pain medicine cause a problem?

None Mild Moderate Severe

	None	Mild	Moderate	Severe
Nausea				
Constipation				
Drowsiness				
Confusion				
Dry mouth				
Headache				
Weight gain				
Sexual Problems				

List all medications & dosages you currently take.

Did you achieve your physical goals since your last visit? (activities your pain prevented you from doing)

No Didn't try Almost achieved Achieved

Achieved and more

What new goals have you made? _____

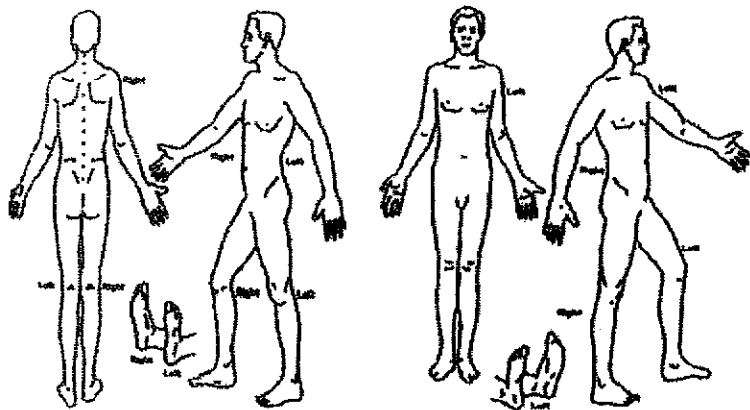
Please indicate where your present pain is:

///= Stabbing

XXX= Burning

==/= Numbness

000= Pins & Needles



Since your last visit have you had and changes to:

Your medical history: _____

Your surgical history: _____

Have you experienced any major life changes/events? _____

Please list any concerns in order of importance, that would like to discuss. _____

Print name: _____

Sign name: _____