**SOAR SPINE & ORTHOPEDICS**

**MEDICAL UPDATE FORM**

**Name:**

**Pain**

Please Rate **0**=No Pain **10**=Extreme Pain

Right Now: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

At Worst: 0 1 2 3 4 5 6 7 8 9 10

**Type of Pain** (aching, stabbing, burning, weakness, numbness, etc.):

**What makes your pain better?**

**What makes your pain worse?**

**Psdafasdfin Location:**

**Type of pain** (ex: aching, stabbing, burning, numbness, tingling, etc.):

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**Pain Location:**

**Type of pain** (ex: aching, stabbing, burning, numbness, tingling, etc.):

**Pain Location:**

**Type of pain** (ex: aching, stabbing, burning, numbness, tingling, etc.):

**Date:**

**Date** **of Birth:**

**MR#:**

***Please mark the body part you are being seen for toda*y**

**Have you had or are you scheduled for the COVID Vaccine? Yes NO**

**Any change in your medical history? (Circle one) \*\*IF YES\*\***

Yes No **Booster Date: \_\_\_\_\_\_\_\_\_\_\_\_**

\*If yes please elaborate:

**Any change in your medications? (Circle one)**

Yes No

\*If yes please elaborate:

**Since your last visit are you: (circle one) Percent Better or Worse:**

Better Worse Same 0 10 20 30 40 50 60 70 80 90 100

**Are you currently in Physical Therapy/other Treatment? (Circle one)**

Yes No Completed