Valley Pain Centers

DAILY PATIENT VISIT FORM

PATIENT NAME: _____ **DOB:** _____ **DATE:**_____

WHEN IS THE LAST TIME YOU HAD ANYTHING TO EAT OR DRINK? _____

TODAY'S COMPLAINT (Area we are currently treating) _____

LOCATION (Where do you have pain? Please note both chief complaints and any secondary issues) _____

_____

QUALITY (Describe your pain & where does it radiate to?) _____

_____

SEVERITY (On a scale of 1-10, circle your pain level)
(Does it affect your daily life? Ability to work, sleep, etc?)

DURATION (How long have you experienced this pain?) _____

TIMING (Is your pain worse at any particular time of day or is it relatively constant?)_____

MODIFYING FACTORS (Is your pain worse when sitting, walking, standing, bending or laying down?) _____

_____

PAST HISTORY OF SYMPTOMS (Has this pain occurred before in your life?) _____

_____

SINCE MY LAST VISIT, MY PAIN IS : (circle one) **N/A** **IMPROVING** **NO CHANGE** **WORSE**

SINCE MY MOST RECENT PROCEDURE, MY PAIN IS: (circle one) **N/A**

ARE THERE ANY OTHER AREAS OF CONCERN THAT YOU WOULD LIKE TO DISCUSS TODAY? _____

_____

ANY CHANGES IN HEALTH HISTORY OR MEDICATIONS SINCE YOUR LAST VISIT? _____

_____

SIGNATURE: _____