Valley Pain Centers

DAILY PATIENT VISIT FORM

PATIENT NAME: ______________________ DOB: ____________ DATE: ____________

PHARMACY: ______________ LOCATION: ______________________ PHONE: ____________

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

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

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? ______________

____

LIST ANY ALLERGIES AND THE REACTION: ______________________

____

SIGNATURE: ____