Name: _____ **Date:** _____

Symptom Intake

1. What is the purpose of your visit today? Circle One:
   Existing Issue Injection Follow Up Med Refill New Issue
2. How are your symptoms since last time you were seen? Circle One:
   Better Worse Same
3. In a few words, what are your symptoms? _____

4. What is your **current** pain level on a scale from 0 to 10, with 0 being no pain and 10 being worst imaginable pain? _____
5. What was your **worst** pain level in the last few weeks? _____
6. What was your **best** pain level in the last few weeks? _____

7. How would you describe your pain? Circle One:
   Burning Stabbing Aching Pins and Needles
8. What activities increase your pain? Select all that apply.

Walking Changing Positions Sitting/ Driving Lying Down Coughing/ Laughing/ Sneezing Standing

9. Are there any other activities that increase your pain? _____

10. What activities decrease your pain? Select all that apply.

Ice/ Heat Rest Changing Positions Stretching Lying Down Medications

11. If you selected medications, which medications are helping? _____

12. I also have: (you may select more than one)
    Hand Weakness Hand Clumsiness Hand Numbness/ Tingling Balance Problems
    Leg/ Foot Numbness/ Tingling Leg/ Foot Weakness Tripping/ Stumbling/ Falling
13. How would you rate your activity level? Circle One:
    I am able to do whatever I choose I have to limit some of my activities
    I have several restrictions in my lifestyle and at work.
14. What is your current work status? Circle One:
    Working, Full duty Working less because of this problem Not Working/ Disabled/Retired
15. How effective are your medications? _____%

16. Are you more active on your medications? Yes or No

17. Are you having any side effects from your medication? Yes or No

REVIEW OF SYSTEMS: Have you had any of the following symptoms in the **last 6 months?** (Mark with an "X")

GENERAL: □ No Problems
□ Fever/Chills
□ Weight Loss
□Weight Gain
□ Fatigue/Weakness

EYES: □ No Problems
□ Blurry Vision
□ Double Vision
□ Change in Vision
□ Glasses/Contacts/Lasik

EARS, NOSE, MOUTH, THROAT: □ No Problems
□ Ringing in Ears
□ Hearing Loss
□ Congestion
□ Allergies
□ Nose Bleeds
□ Sore Throat
□ Teeth/Gum Disease
□ Swollen Glands

CARDIOVASCULAR: □ No Problems
□ Chest Pain
□ Swollen ankles/feet/hands
□ Palpitations
□ Blood Pressure Problems
□ Heart Problems

RESPIRATORY: □ No Problems
□ Wheezing
□ Cough
□ Shortness of Breath
□ Asthma
□ Spitting up Blood

SKIN/BREASTS: □ No Problems
□ Dry Skin
□ Skin Lesions/Rash/Moles
□ Pigmentation Changes
□ Change in Skin Color
□ Itching

NERUO/PSYCH: □ No Problems
□ Numbness/Tingling/Tremors
□ Fainting/Dizziness
□ Depression
□ Anxiety/Excessive Stress
□ Memory Loss/Confusion/Cloudiness
□ Sleep Disorder/Insomnia
□ Head Injury
□ Headaches
□ Seizures
□ Balance Issues

HEMATOLOGY/ENDOCRINE: □ No Problems
□ Anemia
□ Bleeding/Easy Bruising
□ Blood Clots
□ Heat/Cold Intolerance
□ Hormone Problems
□ Diabetes
□ Excessive Thirst or Urination
□ Slow Healing Wounds
□ Night Sweats

GASTROINTESTINAL: □ No Problems
□ Abdominal Pain
□ Nausea/Vomiting
□ Heartburn
□ Blood in Stool
□ Constipation/Diarrhea
□ Liver Disease
□ Loss of Appetite

GENITOURINARY: □ No Problems
□ Painful Urination
□ Frequent Urination
□ Blood in Urine
□ Incontinence
□ Kidney Disease/Stones
□ Sexual Difficulty

MUSCULOSKELETAL: □ No Problems
□ Joint Pain/Stiffness
□ Joint Swelling
□ Muscle Weakness
□ Back Pain
□ Chest Wall/Rib Pain
□ Cold Extremities
□ Extremity Pain (Arms/Legs/etc)
□ Loss of Motion/ Difficulty Walking
□ Amputation